

**DEPARTMENT OF SURGERY
HARTFORD HOSPITAL
RULES AND REGULATIONS
2007**

**ARTICLE I
Name/Purpose**

Section 1

Par. 1. The name of this organization shall be the "Department of Surgery of the Medical Staff of Hartford Hospital".

Par. 2. The purpose of the Department of Surgery is to provide the highest quality of care to all patients who require surgical consultation/care; to provide education to residents, fellows, medical students and other adjunct personnel as well as patients and families; and to pursue clinical research in order to contribute to the body of scientific knowledge.

**ARTICLE II
Officers**

Section 1

Par. 1. There shall be a Director, Associate Director(s), and Assistant Director(s) in a number commensurate with the level of administrative duties.

Par. 2. The Director shall be selected according to the Bylaws of the Medical Staff of Hartford Hospital, ARTICLE VI, Section 1a.

Par. 3. The Associate Director(s) and Assistant Director(s) shall be appointed by the Director according to the Bylaws of the Medical Staff of Hartford Hospital, ARTICLE VI, Section 1b.

Par. 4. The duties and responsibilities of the Director shall be according to the Bylaws of the Medical Staff of Hartford Hospital, ARTICLE VI, Section 1a, Pars. 3 and 4.

4-1 The Director shall assign the members of the Active Staff to their various duties including special assignments.

4-2 The Director shall assign the members of the House Staff to their various duties including special assignments in conjunction with the Associate Director(s).

- 4-3 The Director shall preside over the Department's Executive Committee meetings.

ARTICLE III Organization

Section 1 Department Divisions

Par. 1. The Department of Surgery shall be organized into divisions, to include, but not be limited to, General Surgery, Plastic/Reconstructive Surgery, Cardiovascular Surgery, Vascular Surgery, Thoracic Surgery, Transplant Surgery, Podiatric Surgery, Surgical Oncology, Bariatric Surgery, and Surgical Critical Care. Other Divisions may be designated by the Director of the Department.

- 1-1 Each Division shall have written Rules and Regulations concordant with those of the Department of Surgery. These Rules and Regulations shall include a policy for delineation of privileges for procedures and other activities that the Department members or Director deem necessary.
- 1-2 Membership in a Division will be granted and maintained by application to and an appointment by the Director of the Department of Surgery with input from the Division Chief.
- 1-3 Each Division will have a division chief who will report directly to the Director of the Department of Surgery. The Division Chief will be appointed by the Director of the Department of Surgery with input from the Executive Committee for each section.
- 1-4 Duties of the Division Chief will include, but not be limited to, oversight of Section operations, Quality Assurance/Quality Improvement; Creation of Administrative Reports, participation in the Medical Staff Appointment process, participation in educational processes for department members and ancillary staff, supervision and direction of resident staff education, and collaboration with their UCONN counterpart with regards to education, research and clinical programs
- 1-5 Term of appointment of the Division Chief will be 3 years and will be indefinitely renewable based upon performance reviews.
- 1-6 Reappointment will be by the Director of the Department with input from the Executive Committee.
- 1-7 A stipend may be provided for services provided.

Section 2
Executive Committee
(Voting Members)

Par. 1. The Director, Associate Director(s) and Assistant Director(s) shall be members of the Executive Committee. The Director of the Department shall act as Chairman of the Executive Committee. The Director may appoint the Associate Director to serve as Chairman of the Executive Committee.

Par. 2. Eight additional members of the Executive Committee shall be chosen for a -three year term of office as follows:

- a. The department membership shall elect five (5) members as follows (no more than one person from each service):
 - ◆ three from: Cardiothoracic, Vascular Surgery, Thoracic Surgery, Plastic Surgery, Transplantation, Critical Care, Surgical Oncology (See Appendix III) and Podiatry
 - ◆ two from General Surgery
- b. The Director shall name three (3) members to the Executive Committee from among the Active Staff of the Department. The Director's choices will attempt, among other considerations, to achieve a balanced representation among divisions. These names shall be presented at the March Department meeting.
- c. These eight members shall be limited to two (2) consecutive three (3) year terms on the Executive Committee.

Par. 3. The Executive Committee shall be empowered to review all business of the Department including oversight of quality of care and shall report to the Department for information and ratification.

Par. 4. The Executive Committee shall meet monthly unless otherwise determined by the Director.

Par. 5. The Executive Committee shall be duly constituted and begin its term at the March meeting.

ARTICLE IV
Staff Appointment

Section 1
Active (Voting) Staff

Par. 1. In accordance with Bylaws of the Medical Staff of Hartford Hospital, ARTICLE II, Section 2, candidates for appointment to the Active Staff (Voting) shall first be approved by the Director of the Department. Candidates shall be appointed on the basis of their proven professional ability, demonstrated contributions to the development of their specialties, previous scientific achievement, demonstrated ability in and devotion to administrative duties and teaching, and their interest, imagination and vision in advancing the mission of Hartford Hospital. Department members will be entitled to vote on the applications, and although this vote cannot be binding, it would be a recommendation to be considered by the Director before the appointment is made.

Par.2. In making any recommendation for a candidate's appointment to the Active Staff in the Department of Surgery, the Director shall be subject to the provisions of any policies, procedures, or guidelines adopted or established by the Executive committee of the Board of Directors pursuant to its policy relating to the Hospital Medical Staffing plans adopted July 14, 1983.

Par. 3. Active Staff of the Department of Surgery will attend and participate in a minimum of 20% of the appropriate Morbidity and Mortality Conferences. The failure to do so will subject the active staff person to disciplinary proceedings as outlined in Section 5, par. 1 and 2 of the Bylaws of the Medical Staff of Hartford Hospital addressing disciplinary proceedings which include limitations to, the revocation of, termination or suspension of privileges.

Par. 4 The Active Staff of the Department of Surgery is expected to attend at least 50% of the departmental faculty meetings at which time information regarding the business and operations of the Department of Surgery is discussed. All information/minutes from Department meetings will be distributed to the Active Staff.

Par. 5 Active Staff are expected to demonstrate regular participation in the teaching activities of the Department.

Par. 6 Willingness to serve on standing and/or Joint Medical Staff Committees is a requirement for continued Active Staff status.

Par. 7 Active Staff are expected to participate in the quality improvement (QI) process of the Department of Surgery including the prompt return of requested summaries and informational reports regarding patients identified for case review. The failure to comply with quality assurance/quality improvement initiatives will subject the Active Staff person to disciplinary proceedings as outlined in Section 5, Par 1 and 2 of the Bylaws of the Medical Staff of Hartford Hospital.

Par. 8 Active Staff will maintain CME activity consistent with the policy of their respective American Boards of Certification. CME requirement for the Department of Surgery Active Staff shall be 50 CME credits per year. These credits can be of any class. Forty (40) of these credits must be in the practitioner's primary specialty

Par. 9. An applicant for privileges in the Department of Surgery shall be required to demonstrate and maintain as a condition of privileges such coverage arrangements as approved by the Director of the Department

Par. 10 Certification or eligibility for certification by the American Board of Surgery or in their chosen specialty (American Board of Thoracic Surgery for Cardiothoracic surgeons, American Board of Vascular Surgery and/or American Board of Surgery for Vascular Surgeons, American Board of Podiatric Surgery for Podiatrists and the American Board of Plastic Surgery for Plastic Surgeons) will be required for obtaining privileges in the Department of Surgery. Maintenance of valid certification will be mandatory for continuation of privileges in the Department of Surgery. In accordance with the recommendation of the American Society of Transplant Surgeons, the candidate for active staff in Transplant Surgery must successfully complete an accredited two year fellowship in transplant surgery.

Par. 10a An exception to the above: Clinical privileges may be granted to individual physicians whose sole purpose will be to provide continuity of care for in-patients. These physicians shall be appointed to the Affiliated Clinical Staff. Privileges pertaining to the Affiliated Clinical Staff shall not be considered privileges to practice independently nor do they include the privilege to admit. The Affiliated Clinical Staff will also be exempt from the mandated certification within 5 years of eligibility.

Section 2
Courtesy Staff
(Non-voting)

Par. 1. Appointment to the Courtesy Staff in Surgery shall be made according to the Bylaws of the Medical Staff of Hartford Hospital Article II, Section 2, par. 3, and will be governed by Bylaws of the Medical Staff of Hartford Hospital ARTICLE III, Section 7.

Par. 2. In making recommendation for a candidate's appointment to the Courtesy Staff in the Department of Surgery, the Director shall be subject to the provisions of any policies, procedures, or guidelines adopted or established by the Executive Committee of the Board of Directors pursuant to its policy relating to the Hospital Medical Staffing Plans adopted July 14, 1983.

Par. 3. Specific surgical privileges of Courtesy Staff will be defined by the Department Director and will be reviewed biennially. Courtesy Staff will submit evidence for CME accreditation consistent with the appropriate American Board certification prior to annual appointment.

Par. 4. Accredited Board Certification or eligibility for certification (or successful completion of a two year accredited fellowship in transplant surgery if position is in transplant surgery) by the American Board of Surgery or in the chosen specialty (See Section 1, Par. 5) will be required for obtaining courtesy privileges in the Department of Surgery. Maintenance of valid certification will be mandatory for continuation of privileges in the Department of Surgery. An exception to this is a physician who may not have completed surgical residency training, and is contracted exclusively to provide house-staff/adjunct level on-call coverage. This physician must be licensed to practice medicine in the State of Connecticut.

Par. 5. The Director or his designate reserves the right to request that each patient admitted by a member of the Courtesy Staff have a written pre-operative consultation to determine the necessity and appropriateness of the proposed case or operation.

Par. 6. The Director or his designate reserves the right to actively assist on every operation performed by a Courtesy Staff member.

Par. 7. In order to retain an appointment to the Courtesy Staff each surgeon shall care for a minimum of 5 patients per year (in-patient or out-patient) at Hartford Hospital. This may be subject to maximum limits from time to time as

determined by the Director. The Director can make exceptions, which will be presented to the Department of Surgery Executive Committee. (Similar to Article IV, Section 1, Par 1). Physicians who are contracted exclusively to provide on-call coverage (see Par. 4) are exempt from this requirement.

Par. 8. Courtesy Staff in Surgery will pay annual dues of \$100 per annum.

Par. 9. Courtesy Staff in Surgery will attend the M&M Conference following surgery performed at Hartford Hospital when appropriate for subsequent case discussion. Timely notice will be given.

Par. 10. An applicant for Courtesy Staff privileges in the Department of Surgery shall be required to demonstrate and maintain as a condition of privileges such coverage arrangements as approved by the Director of the Department.

Section 3 Reappointment and Promotion

Par. 1. Recommendations for reappointment shall be according to the Bylaws of the Medical Staff of Hartford Hospital ARTICLE III, Section 10.

Par. 2. Recommendations for promotion shall be according to Medical Staff of Hartford Hospital ARTICLE III, Section 11. Promotions shall be recommended by the Department Director and shall be based upon professional ability, contribution to specialty, scientific achievement, administrative duties and teaching and participation in hospital affairs.

Section 4 Adjunct Medical Staff

Par. 1. Adjunct Medical Staff will be subject to the Bylaws of the Medical Staff of Hartford Hospital Article III, Section 8, par. 1.

Par. 2. Adjunct Staff (Physicians Assistants, APRN's and other non-physicians) who are candidates for assignment to the Department of Surgery must be graduates of an accredited program and be certified or eligible for certification by the National Commission of Certification in their discipline.

Par. 3. Adjunct Medical Staff assigned to the Department of Surgery shall be accountable to the Director of the Department of Surgery or his licensed designate.

Par. 4. Adjunct Medical Staff assigned to the Department of Surgery shall provide a variety of routine diagnostic and therapeutic patient care services pre-operatively, intra-operatively and post-operatively under the direction of the Director of the Department of Surgery or his licensed physician designate. These services shall be performed on patients cared for by staff physicians and residents in the Department of Surgery. They shall be involved with the care of the patient in any role the supervising physician deems appropriate provided that it is in accordance with the following: Applicable medical statutes, the Connecticut Nurse Practice Act, Hartford Hospital By-Laws and Operating Room Rules, Policies and Procedures. In all instances Adjunct Medical Staff members act as agents of the physician with whom they work.

Par. 5. Adjunct Medical Staff are expected to attend and participate in a minimum of 20% of the appropriate Morbidity and Mortality conferences. Failure to do so will subject the staff person to disciplinary proceedings as outlined in Section 5 Par 1 and 2 of the Hartford Hospital Medical Staff By-Laws.

Par. 6. Adjunct staff will also maintain CME activity consistent with the policy of their respective American Boards of Certification.

Section 5 Honorary Staff

Par. 1. Honorary Staff shall consist of those surgeons who do not actively practice at Hartford Hospital but are deemed worthy of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous longstanding service to the hospital and its Department of Surgery, and who continue to exemplify high standards of professional and ethical conduct.

Section 6 Podiatric Physicians

Par. 1. Appointment as a Podiatrist shall be made according to the By-Laws of the Medical Staff of Hartford Hospital, Article II, Section 2, Par. 3 and will be governed by the By-Laws of the Medical Staff of Hartford Hospital Article III, Section &.

Par 2. All podiatrists at Hartford Hospital will have dual appointments within the Departments of Orthopedics and Surgery.

Par. 3. All podiatrists shall meet the following eligibility criteria requirements:

- 3-1 Must be graduates of an accredited four year college of podiatric medicine and shall have completed at least two years certified post-graduate training following graduation in a hospital approved by both the Committee on Podiatric Education and the Joint Commission on Accreditation of Hospitals. A PSR 24 shall be construed as the minimum requirement for surgical privileges at Hartford Hospital. Podiatrists with admitting privileges shall be required to meet a minimum annual surgical case load required by the Department of Surgery as well as that for the Department of Orthopedics.
- 3-2 Shall be certified by the Connecticut State Board of Examiners in Podiatry and shall hold an unrestricted license to practice in the state of Connecticut.
- 3-3 Shall be certified by or qualified for certification by the American Board of Podiatric Surgery. Board qualified podiatrists must complete their certification within five (5) years of their qualification certificate.
- 3-4 All podiatrists who are board certified prior to January 1, 2002, and who maintain their recertification with the American Board of Podiatric Surgery, as well as having already been admitted to the Hartford Hospital Active Podiatric Medical Staff, shall be able to maintain their active status by meeting the minimum annual surgical case load required by both the Departments of Surgery and Orthopedics.

Par. 4. In making recommendation for a candidate's appointment, the Director shall be subject to the provisions of any policies, procedures or guidelines adopted by the Executive Committee of the Board of Directors pursuant to its policy relating to the Hospital Medical Staffing Plans adopted July 14, 1983.

Par. 5. Specific surgical privileges shall be defined by the Directors of Surgery and Orthopedics as well as the Podiatric Divisional Chairman and be consistent with the ABPS 110 Requirements for Board Certification and Qualification. Privileges will be reviewed annually. All podiatrists will submit evidence for CME accreditation consistent with the appropriate Board certification and with the requirements stated in the Department of Surgery By-Laws prior to annual appointment.

Par. 6. Podiatric patients admitted to Hartford Hospital for ambulatory surgical procedures requiring sedation and local anesthesia only may be admitted to the podiatrist's service and will require a history and physical performed by the patient's medical physician 30 days prior to or on day of admission to Hartford Hospital and will be placed in the patient's record within the first twenty-four

hours (24 hours) of the admission. An exception to this is that the history and physical may be performed by the attending podiatrist for ASA Class I and II patients as determined by the Department of Anesthesiology.

- 6-1 In the event of a medical emergency or misadventure, the Attending Podiatrist will be notified. It will then be the Attending Podiatrist's responsibility to notify the appropriate consulting physician to address the situation.

Par. 7. Podiatric patients admitted to Hartford Hospital for podiatric procedures requiring general anesthesia may be admitted to the Service of the Podiatrist and shall have a mandatory medical and/or surgical consult. A history and physical will have been performed by an MD within 30 days prior to admission and will be placed in the patient's record within the first twenty-four (24) hours of admission. An exception to this is that the history and physical may be performed by the attending podiatrist for ASA Class I and II patients as determined by the Department of Anesthesiology.

Par. 8. The Director of the Department of Surgery or his designee reserves the right to request that each patient admitted to the Podiatric Service have a written pre-operative consultation to determine the necessity and appropriateness of the proposed operation. The podiatrist will be responsible for the podiatric assessment and treatment of the patient and will be allowed to use any means within his/her scope of practice to attain the appropriate goals within the framework of podiatric licensure.

- 8-1 Documentation of a plan of care/treatment must be evident in the patient record and updated in a timely manner.

Par. 9. All podiatrists shall participate in the quality improvement process for the department. In the event that a complication or death of a patient admitted to the Podiatric service occurs, the case will be presented at the Podiatric M&M conference or at another appropriate M&M conference e.g. Vascular or General Surgery. The attending Podiatric Surgeon will be required to attend that conference for the purpose of case discussion. All discussions and final results of said discussions shall be documented and kept on file for three years (Statute of Limitations). The podiatric surgeons are encouraged to attend those conferences to comply with the 20% attendance rule for reappointments to the Department of Surgery.

Par. 10. Podiatrists may be granted consulting staff privileges in order that they may provide consultative foot care for Hartford Hospital patients not requiring anesthesia. The Division Chief will review this on a case by case basis.

ARTICLE V
Meetings

Section 1
Meetings

Par. 1. Twenty (20) percent of the total voting membership of the Department shall constitute a quorum at Faculty/Department Meetings.

Par. 2. Special meetings may be called at any time by the Director or by a quorum of the members of the Department.

Par. 3. Divisional and/or Service Morbidity and Mortality Conferences shall be held at reasonable intervals at which time selected deaths and complications shall be reviewed and recorded.

Par. 4. A special quality improvement committee, appointed by the Director, shall hold meetings at least twice per year to review cases of potential legal, quality and/or risk management issues.

Par. 5. A Surgical Collaborative Management Team will meet at least monthly to discuss issues that transcend disciplines. This team shall be comprised of the Director, Associate Director, Assistant Director, Data Manager, Medical Director of each surgical ICU, and the Nursing Directors for General Surgery, Cardiovascular/Cardiology and Neurotrauma. In addition, Ad hoc members e.g. Quality Management will be invited as issues arise.

Par. 6. A Department of Surgery Hospital-based Faculty Meeting will meet at least monthly to discuss pertinent hospital-based issues. All hospital-based faculty are expected to attend.

Section-2
Place and Notification of Meetings

Par. 1. The place of each meeting is to be specified by the Director and each member will be notified of the time and place of each meeting at least one week before the meeting scheduled.

ARTICLE VI
Department Activities

Section 1
Standards of Practice

Par. 1. The oversight of the quality of patient care, treatment and services provided by the practitioners privileged within the Department of Surgery remains with the Director of the Department with input from the Division Directors, Credentials Administrator and peer review.

Par. 2. Practitioners privileged within the Department of Surgery shall practice only within the scope of their privileges.

Par. 3. The patient's general medical condition is managed and coordinated by a physician with appropriate privileges unless otherwise delegated.

Par. 4. The practitioner must have privileges that correspond to the care, treatment and services needed by the patient.

Par. 5. A written Peer Review/Quality Management program is in place for the review of adverse events and deaths. This review is educational and not punitive and provides for an in-depth review of events, discussion of possible causes and possible interventions and eventual closure. (See schematic).

Section 2
Credentialing/Rec credentialing

Par. 1. All members of the Active and Courtesy Staff of the Department of Surgery will be certified by their appropriate board within a period not to exceed 5 (five) years from the date of demonstrated eligibility. (Please refer to Article IV, Section 1, Par. 5)

Par. 2. Delineated surgical privileges for Active and Courtesy Staff will be reviewed biennially by the Department Director according to the By-laws of the Medical Staff of Hartford Hospital, Article III, Section 10, Par. 1-3. Any disputes over delineation of privileges will be resolved by the procedure stated in the By-laws of the Medical Staff of Hartford Hospital, Article III, Section 10, Par. 4-7.

Par. 3. The credentialing/rec credentialing process will include, but not be limited to, an overview of licensure, education, training, current competence and physical ability.

Par. 4 The credentialing/recredentialing process will also include documentation of competency in the following areas: Patient Care, Medical/clinical knowledge, Practice-based learning and improvement, Interpersonal and communication skills, professionalism and systems-based practice.

- 4-1 The evaluation may include chart review, database review (MedPar/Delta, and HH specific databases), peer review, review of educational pursuits, and mandatory meeting attendance.

Par. 5. The credentialing/recredentialing process shall be ongoing and shall be based upon continuous evaluation of the practitioner's performance. This will allow for early identification and resolution of problems as well as evidence-based privilege renewal.

Par. 6. Issues with a practitioner's performance related to credentialing will undergo a focused professional practice evaluation. This evaluation includes, but is not limited to, chart review, review of morbidity/mortality data, observation of performance and peer review.

- 6-1 Issues will include, but not be limited to, activities or conduct constituting negligence, unethical behavior or compromising patient safety.
- 6-2 Written guidelines will determine when and what type of corrective action will take place (suspension, summary suspension, termination, etc) (See Medical Staff By-Laws, Article II, Section 5).
- 6-3 Should a hearing become necessary, the By-laws of the Medical Staff will be followed (See Article II, Section 5 of the HH By-laws).

Section 3 Mechanism for Credentialing New Procedures

Par. 1. New surgical procedures will be called to the attention of the Department Director who will, in consultation with those individuals involved in the new procedures, establish recommended credentialing criteria. These recommended credentialing criteria will be approved by the Executive Committee. Requirements specific to the granting of privileges in certain areas will depend upon quality of performance.

Par. 2. Examples of developing criteria for new procedures (Credentialing for Laparoscopic-Surgery)

A. **Credentialing for Category II Procedures**

1. Diagnostic Laparoscopy and Biopsies

- a. Using Supervision--Surgeons seeking diagnostic laparoscopy privileges need to perform at least five (5) procedures under the direct supervision of an experienced laparoscopic surgeon at Hartford Hospital. Documentation of data and case by name or hospital number must be recorded and submitted to the Department Director.
- b. Combining existing skills or prior training with additional didactics, experience and/or preceptorship – Surgeons seeking laparoscopic cholecystectomy and/or appendectomy privileges must satisfy one of the following criteria in addition to qualifying for requisite delineation of privileges which allow open biliary tract surgery or appendectomy:
 - i. Must have documentation of appropriate residency or fellowship training in laparoscopic cholecystectomy or appendectomy
 - ii. Must participate in the operative procedure at Hartford Hospital or another facility with an established program
 - iii. Must complete at least the first ten (10) clinical cases under the preceptorship of an experienced laparoscopic surgeon and achieve acceptable outcomes
 - iv. For the credentialing of new laparoscopic procedures, Section 5, Par. 3 applies

B. **Credentialing for Category III Procedures i.e. Advanced Laparoscopic Surgery**

1. All surgeons must be credentialed in diagnostic laparoscopy, laparoscopic cholecystectomy and appendectomy
2. All surgeons must have delineation of privileges which allow the open procedures in that specific area.
- 3a. All surgeons must demonstrate appropriate didactic training and laparoscopic skills in the area of advanced laparoscopic surgery for which privileges are requested. This will delineate some procedures requiring suturing and stapling skills.
- 3b. All surgeons must participate in and successfully complete, the training process for the procedure at Hartford Hospital or at another

facility with an established program.

- 3c. All surgeons will complete at least the first ten clinical cases under the preceptorship of an experienced laparoscopic surgeon and achieve acceptable outcomes.
4. For applicants who cannot demonstrate adequate residency or fellowship training but can provide evidence of basic laparoscopic skills e.g. laparoscopic appendectomy and/or cholecystectomy, the first five (5) clinical cases in any category of advanced laparoscopy will be performed under the preceptorship of an experienced laparoscopic surgeon.
5. For the credentialing of new laparoscopic procedures, Section 5, Par. 3 applies.

C. Credentialing for Endovascular Procedures (See Appendix I)

D. COMBINING EXISTING SKILLS OR PRIOR TRAINING WITH ADDITIONAL DIDACTICS, EXPERIENCE AND/OR PRECEPTORSHIP FOR CATEGORY 2 PROCEDURES

Laparoscopic Cholecystectomy and/or Appendectomy

The following criteria must be satisfied prior to the awarding of privileges:

1. All surgeons who wish to perform laparoscopic cholecystectomy or appendectomy will have delineation of privileges which permit open biliary tract surgery or appendectomy.
2. Documentation of appropriate residency or fellowship training in laparoscopic cholecystectomy or appendectomy.
- 3a. Demonstrate appropriate didactic training and laparoscopic skills in the area of advanced laparoscopic surgery for which privileges are requested. This will delineate some procedures requiring suturing skills and stapling skills.
- 3b. Participate in the operative procedure at Hartford Hospital or another facility with an established program.
- 3c. At least the first ten clinical cases will be performed under the preceptorship of an experienced laparoscopic surgeon and achieve acceptable outcomes.
4. For the credentialing of new laparoscopic procedures, Section 5, Par. 3 applies.

Par. 5 Laser Surgery

1. The guidelines established by the Laser Committee apply i.e. ten (10) CME credits in courses which include both laser safety, training and hands-on experience.
2. Documentation of successful completion of didactic courses must be provided.
3. The first five (5) clinical cases must be performed under the preceptorship of an individual experienced in the use of the laser. This may be another physician on staff or a representative from the manufacturer.
4. Credentialing for laser privileges is awarded by the Department of Surgery after review and recommendation for approval by the Laser Committee.

Par. 6 Vascular and Cardiothoracic Surgery

1. Certification or eligibility for certification in general vascular surgery by the American Board of Surgery will be the standard means of obtaining privileges in the Division of Vascular Surgery in the Department of Surgery. Maintenance of certification in general vascular surgery by the American Board of Vascular Surgery will be mandatory for continuation of privileges in the Division of Vascular Surgery in the Department of Surgery.
2. Certification or eligibility for certification in cardiothoracic surgery by the American Board of Thoracic Surgery will be the standard means of obtaining privileges in the Division of Cardiothoracic Surgery in the Department of Surgery. Maintenance of certification in cardiothoracic surgery by the American Board of Thoracic Surgery will be mandatory for continuation of privileges in the Division of Cardiothoracic Surgery in the Department of Surgery.
3. Qualifications for surgical privileges to perform operative arterial stent graft procedures:
 - a. Arterial stent graft procedures for aneurysms are considered advanced vascular operations and as such, require board certification in vascular surgery.

- b. Documentation must be provided to show that the applying surgeon has completed a course of study specific to the type (manufacturer and specific site of deployment) of the stent graft under consideration.
 - c. Documentation must be presented attesting to assisting with at least thirty (30) implants performed by a credentialed surgeon.
 - d. Documentation must be provided attesting to at least five (5) primary operator implants under the supervision of a credentialed surgeon.
 - e. Once the above has been successfully completed by the applying surgeon, temporary privileges for performing arterial stent graft procedures will be recommended by the Chief of Vascular Surgery to the Director of the Department of Surgery. The results of the first five independently placed arterial stent graft insertions will then be reviewed by the Chief of Vascular Surgery and reported to the Director of the Department of Surgery. If that experience is successful, full privileges in arterial stent graft procedures will be given to the applying surgeon.
 - f. If the vascular surgeon is not yet qualified for surgical privileges for arterial stent graft procedures, he/she can work as a primary or secondary operator with a vascular/interventional radiologist and a certified vascular surgeon who possess credentials for arterial stent graft procedures. The surgeon's opinion is often critical in determining the outcomes of these procedures. Therefore, both interventional radiology and endovascular surgery need to participate with non-certified surgeons, as well as non-certified radiologists.
 - g. At least five (5) of these procedures must be done annually to maintain credentials.
 - h. A certified endovascular surgeon has the choice of performing these procedures by himself/herself or with the assistance of a certified interventional/vascular radiologist.
4. Credentials to Place Thoracic Aortic Stent Grafts
- a. The placement of thoracic aortic stent grafts is considered an advanced vascular surgical procedure. In order to perform this advanced procedure, the practitioner must fulfill/abide by one of the following criteria:
 - b. In order to perform this procedure independently, the practitioner must possess an understanding of the disease entity including knowledge of and expertise in all of the available

therapeutic options, post procedural care and potential complications. The practitioner must have successfully completed an ACGME approved Vascular, Thoracic or Cardiothoracic Surgical Fellowship and hold current board certification in vascular and/or cardiothoracic surgery. The practitioner must also be credentialed to perform either thoracic, vascular and/or cardiothoracic surgery at Hartford Hospital.

- c. The practitioner must provide current documentation of successful completion of an accredited CME program(s) dedicated to this technology . The practitioner also must provide documentation of outcomes/results of at least 20 procedures performed. This can be in provided as case logs from a fellowship.
- d. The practitioner must be experienced in the traditional surgical procedures used to treat thoracic aortic disease:
 - i. Management of thoracic aortic disease by conventional open surgical techniques.
 - ii. Successful performance of at least 25 catheter placements involving guide-wire technology in the current past two years
 - iii. Participation in the successful placement of 10 abdominal or 5 thoracic aortic endovascular stent grafts.
 - iv. Experience with placement of large-bore catheters into the femoral and iliac arteries.
 - v. Experience with retroperitoneal exposure of the iliac artery and performance of surgical procedures on the iliac and femoral arteries.
- e. Once the practitioner has provided the above documentation of experience, temporary privileges will be granted. The results of the first five (5) stent graft procedures will be reviewed by the Executive Committee of the Department of Surgery. If the experience is satisfactory, full privileges will be granted.
- f. If a surgeon does not meet the above criteria, he/she may be

credentialed to perform the procedure in concert with other physicians who possess the necessary skills.

- i. It is imperative that the necessary experience and expertise be available to provide safe, appropriate, quality care. Therefore, it is essential that physicians from each of the disciplines partner with other physicians e.g. cardiothoracic, thoracic, peripheral vascular, vascular, interventional radiology, endovascular surgery, to provide the necessary expertise
5. Credentialing for endovascular procedures and carotid stenting procedures are defined in Appendices I and II respectively and require the approval of the Division Chief in Vascular Surgery and the Chairman of the Department of Surgery, with input from the Endovascular Credentials Committee.

Par. 7 In accordance with the recommendations of the American Society for Metabolic and Bariatric Surgery, the candidate for active staff in Bariatric Surgery will have credentials to perform gastrointestinal and biliary surgery and be involved in an integrated program for the care of the morbidly obese patient that provides ancillary services such as specialized nursing care, dietary instructions, counseling, support groups, exercise training and psychological assistance if necessary. The candidate must have completed an accredited fellowship in bariatric surgery or have successfully completed at least 25 bariatric procedures in the appropriate category for which the candidate is seeking privileges during surgical residency.

- 7-1 To obtain open bariatric surgery privileges, the candidate must meet the above standards and document an operative experience of 15 open bariatric procedures with successful outcomes during surgical residency or post-graduate training supervised by an experienced bariatric surgeon.
- 7-2 To obtain laparoscopic bariatric surgery privileges that involve stapling or division of the GI tract, the surgeon must meet the global credentialing requirements and have privileges to perform open bariatric surgery, advanced laparoscopic surgery and have documented at least 50 cases with satisfactory outcomes during either general surgery residency or post-residency training under the supervision of an experienced bariatric surgeon.
- 7-3 To obtain laparoscopic bariatric surgery privileges for procedures that do not involve stapling or division of the GI tract, the candidate must meet the global requirements above and have

privileges to perform advanced laparoscopic surgery and have documented at least 10 cases with satisfactory outcomes during either general surgery residency or post residency training under the supervision of an experienced bariatric surgeon.

- 7-4 The surgeon's outcome data will be reviewed at six months and after completion of the first 50 procedures performed independently. Thereafter, evaluation will take place on an annual basis conjointly with reappointment.

Section 3 Research

Par. 1 The Director of the Department shall approve research projects before presentation to the Research Committee of the Staff.

Section 4 Out Patient Department

Par. 1. The Director shall appoint a member of the Department as the Director of the Brownstone Clinic.

Par. 2. This representative to the Surgical Out Patient Department shall, with the Director of the Department of Surgery, assign personnel to the various clinics and be responsible to the Director of the Department for the functioning of said clinics.

Section 5 Operating Room

Par. 1. Each admitted patient undergoing a surgical procedure must have a history, physical examination and preoperative diagnosis entered in his medical record preoperatively and signed by the performing or supervising physician.

Par. 2. The history and physical examination must be completed within 30 (thirty) days of the scheduled procedure and must be signed and dated by the physician performing/overseeing the examination.

Section 6 Resident Supervision

Par. 1. One standard of care is provided for all patients in the Department of Surgery. Staff members supervise all resident activity, inpatient and outpatient, and are immediately available for all operations.

Par. 2. Residents enrolled in University of Connecticut or Hartford Hospital sponsored training programs ~~in~~ within the Department of Surgery will assist in the care of patients admitted to the hospital under the supervision of the attending staff.

- a. Patients may enter the hospital with a pre-established physician-of-record, who is a member of the Attending Staff of the Department of Surgery, and that physician will be responsible for the supervision of resident and student participation in the care of his/her patients.
- b. Patients who enter the hospital without a pre-established attending physician-of-record (Chief's Service, etc.) will have assigned a member of the Attending Staff of the Department of Surgery as the responsible supervising physician according to the call-system published monthly. The responsible attending physician for these patients will be notified immediately of the admission of a patient to the Chief's Service. That attending surgeon will remain the responsible attending throughout the hospital stay of that patient unless this responsibility is transferred to another, and appropriately noted in the chart. The responsible attending surgeon will be informed and concur in advance and will be present and available in the hospital for all operative surgery.

Par. 3. Because residents in training in the Department of Surgery do not provide patient care independently, no delineation of privileges for residents is required.

Par. 4. While the "bedside" supervision of residents in the care of patients is the responsibility of either the attending physician-of-record or the assigned attending physician, the overall responsibility for policies and lines of communication with regard to supervision rests with the Program Director (Department Director or Associate Director).

Section 7
Policies to be consistent with the Bylaws of the
Medical Staff of Hartford Hospital and TJC

Par. 1. The medical staff within the Department of Surgery adhere to Hartford Hospital's informed consent policy (informed consent policy, Section I, Policy 3, Page 1-5 in the Hartford Hospital Policy Manual), "to assure that patients and/or their Guardian fully understand the purpose of potential risks and benefits of the proposed treatment.

Par. 2. All tissue removed during a surgical procedure, except for those specifically exempted by the Tissue Committee of the Medical Staff, must be submitted to the Pathology Department properly labeled. The documentation of the removal of any specimen or medical device not submitted to pathology should be provided by the surgeon in the hand written operative note.

Par. 3. A hand written operative note must appear in the chart immediately. Operative notes must be dictated within 24 hours. Failure to dictate within 24 hours will subject the individual to consequences as delineated by the Health Information Services.

Par. 4. The patient admission History and Physical by the resident staff must appear within 24 hours. The attending surgeon of record shall place a hand-written note in the chart. Failure to appropriately document the medical record will result in due process based on the Medical Staff notification policy.

ARTICLE VII Change in Rules and Regulations

Section 1

Par. 1. The Director of the Department, subject to approval of the Executive Committee of the Surgical Department shall establish or revise rules and regulations for the operation of the department. These changes shall be presented at the next monthly department meeting for approval.

ARTICLE VIII Vacancies

Section 1

Par. 1. Should any elected office of the Department become vacant, it shall be filled at the next meeting of the Department by the same procedure as at the Annual Meeting.

Par. 2. Vacancy in the position of Director shall be filled according to the Bylaws of the Medical Staff of Hartford Hospital, ARTICLE VI, Section 2.

ARTICLE IX
Parliamentary Procedures

Section 1

Par. 1. Robert's Rules of Order (Revised), unless otherwise specified, shall govern all actions of this Department.

Approved Department of Surgery Executive Committee: November 20, 2007

Approved Department of Surgery: December 11, 2007

Executive Committee Medical Staff Council December 17, 2007

Executive Committee Board of Directors April 4, 2005

APPENDIX 1
GUIDELINES FOR CREDENTIALING AND
GRANTING PRIVILEGES FOR ENDOVASCULAR
DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Hartford Hospital Guidelines for Credentialing and Granting Privileges for Endovascular Diagnostic and Therapeutic Procedures

Preamble: The purpose of these guidelines is to establish criteria for granting privileges for endovascular interventional procedures in order to provide patient safety and ensure optimal patient outcome by credentialed, competent physicians.

I. Principles of Endovascular Diagnostic and Therapeutic Privileging

A. Purpose

This guideline outlines the specific requirements that a physician must fulfill to be granted privileges to perform endovascular diagnostic and therapeutic procedures at Hartford Hospital. The guidelines are in accordance with the general principles set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines for granting hospital privileges. These guidelines have been developed to ensure that endovascular interventional procedures are performed in a manner assuring high quality patient care.

This document covers arterial and venous vessels for diagnostic purposes and endovascular therapy. This includes implantation of devices, dilatation, repair and/or stenting of blood vessels secondary to trauma, atherosclerotic disease, aneurysmal disease, venous occlusion or stenosis, bypass of arteries, or shunts.

Credentialing in endovascular therapy is on the basis of the performance of a minimum number of a variety of procedures that show a sufficient exposure to the fundamental endovascular techniques to expect that the competence to perform all presently approved endovascular diagnostic and therapeutic procedures has been attained. The fundamental skills necessary to perform all endovascular procedures are categorized as follows:

1. Gaining access to the vascular system
2. Positioning catheters in various locations

3. Treating conditions by endoluminal dilation or device deployment
4. Assessing the situation before, during and after treatment.

B. Uniformity of Standards

These standards will apply to all physicians who desire to perform endovascular diagnostic and therapeutic procedures. In keeping with current Hartford Hospital practices, the department chief with advisory input from the section chief will apply these guidelines as they assess the ability of the physician requesting privileges to perform these procedures. In addition, the department chief with input from the section chief will institute any other requirements and regulations they deem necessary to deliver high quality patient care.

Scope of Procedures

1. Arterial
 - a. Diagnostic
 - b. Carotid Intervention
 - c. Aortic/Renal/Mesenteric Intervention
 - d. Iliac/Peripheral Intervention
 - e. Lytic Treatment
2. Venous
 - a. Diagnostic
 - b. IVC Filters
 - c. Thrombolytic Treatment
 - d. PTA/Stent
3. AV Access
 - a. Diagnostic
 - b. Therapeutic
 - i. Lytic
 - ii. PTA/Stent

C. Responsibility for Privileging

The privileging for endovascular diagnostic and interventional procedures shall follow the current guidelines for obtaining privileges for new surgical procedures at Hartford Hospital. Delineated surgical privileges for active and courtesy staff will be reviewed biennially by the department director according to the Bylaws of the Medical Staff of Hartford Hospital, Article III, Section 10, Par. 1-3. Any disputes over delineation of privileges will be resolved by the procedure stated in the Bylaws of the Medical Staff of Hartford Hospital, Article ii, Section 2, Par. 13.

D. Definitions

Catheterization: The general term used to denote the positioning of a catheter in a specific location of the vascular system, often, but not always, with the assistance of a guidewire.

Direct Catheterization: Used to describe the simple placement of a catheter directly into a vessel without the use of guidewire advancement of the catheter any further into the vascular system involved.

Selective Catheterization: Refers to the placement of a catheter in a branch vessel of the aorta, vena cava, or of the vascular tree beyond the point of introduction of the catheter into the vascular system. Depending on how distal into the vascular tree the catheter is positioned beyond the starting point, selective catheterizations may be termed a “first”, “second” or “third” order catheterization. (See Appendix)

Documented training and experience: The physician must be board certified or eligible in his-her area of expertise. Before performing any endo-vascular diagnostic or therapeutic procedure, the physician must be proficient in performing the procedure with traditional, open techniques. Current hospital guidelines and privileging will ensure that these criteria are being met.

Privileging: The process whereby a specific scope and content of patient care services (i.e. clinical privileges) are authorized for a health care practitioner by Hartford Hospital based on evaluation of the individual’s credentials and performance.

Competence or Competency: A determination of an individual’s capability to perform up to defined expectations.

Credentials: Documented evidence of licensure, education, training, experience, or other qualifications.

Stent-graft: The marriage of any vascular conduit material PTFE or PET or Polyethylene to a structural lattice such as a metallic stent. The stent is used to give stability to the vascular graft material. The endovascular system is defined as the ability to deliver the device from and intraluminal approach.

Intervention: A therapeutic procedure on a vessel, such as a balloon dilatation, atherectomy, stent placement, caval filter placement, or endoluminal graft implantation.

Formal Course: A formal course that ensures proper understanding of the materials and skills required for endovascular device implantation, diagnostic and therapeutic procedures shall be required. The course will have a curriculum that includes didactic instruction as well as hands on experience utilizing inanimate and/or animate models.

II. Requirements for granting privileges

A. The Applicant must have delineation of privileges that permit open procedures in the specific area.

B. Privileges may be granted on the basis of any one of these delineated measures: Verified training acquired during a residency and/or endo-vascular fellowship program, formal preceptorship, approved post residency courses or practical/experiential training

1. Formal Residency/Fellowship training

Prerequisite training must include satisfactory completion of an accredited surgical (includes subspecialties) residency or endo-fellowship program. Board eligibility and eventual certification by the appropriate certifying body is required. When necessary, the department chief with advisory input from the section chief shall obtain and review documentation of training, e.g. surgical logs.

2. Formal training in endovascular diagnostic and therapeutic procedures

For candidates who successfully completed a residency and/or endo-vascular fellowship program that incorporated a structured experience in endovascular diagnostic and therapeutic procedures, the applicant's program director, and if desired other faculty members, should supply the appropriate documentation of training to the department or division chief. If this documentation meets Hartford Hospital guidelines for establishing skill competence and therefore recommending privileges for endovascular diagnostic and therapeutic procedures, the department chief with advisory input from the section chief may recommend privileges for endovascular diagnostic and therapeutic procedures without

requiring the candidate to repeat the credentialing process at Hartford Hospital.

3. Supervised Preceptorship

- a. All candidates for endovascular diagnostic/therapeutic procedure privileges will observe the procedure being performed by an experienced endovascular surgeon.
- b. An Endovascular surgeon experienced in the procedure being requested must successfully proctor the applicant in the performance of the requested procedure. The department chief with advisory input from the section chief shall determine the number of cases that must be proctored by a trained/credentialed endovascular specialist, a listing of which must be completed prior to a candidate being awarded the privilege. The total number may vary depending on the procedure and the individual surgeon. Once a surgeon is given the privilege, he/she may perform any procedure for which they have surgical privileges and for which the procedure may be appropriate. In the case where endovascular approach has not been used, a credentialed surgeon may perform the procedure providing the Department chairman, with input from the section chief has evaluated and approved the request and determined whether additional training/safeguards may be necessary prior to carrying out the requested procedure.

4. Approved post-residency courses

The Applicant must successfully complete a formal course

5. Practical Training

The applicant must demonstrate appropriate didactic training and skills necessary for the privileges requested. Documented experience may include an appropriate volume of cases in the procedures for which privileges are being considered.

III. Application Process

Individual requests for privileges shall be presented Chairman of the Department of Surgery.

Credentials and privileges will be given through the Department of Surgery. The procedures will be performed under the imprimatur of the Department of Surgery. To qualify for credentials, the applicant must provide written documentation of the following:

1. Board certification as a Vascular Surgeon
 2. That he/she participated on a senior level in at least 100 catheterizations and 50 therapeutic interventions.
 - a. Of the 100 catheterizations, at least half should be selective catheterizations to ensure mastery of the catheter/guidewire skills that are necessary to position catheters in these more specific locations. Seventy-five percent (75%) or more of the 100 required catheterizations should be arterial and up to 25% can be venous. Similarly, at least 75% of the 50 requisite therapeutic interventions must be performed on arterial lesions and the remainder can be venous or dialysis graft procedures.
 3. That he/she acted as the primary interventionist (i.e. performed the critical components) on at least half of the above procedures and been no less involved than a first assistant on the remainder.
 4. That he/she performed at least 25 percutaneous arterial cannulations, all as the primary surgeon with the Seldinger technique.
- IV. The Department Chief with advisory input from the Section Chief shall review the requirements prior to recommending endovascular diagnostic/therapeutic procedures privileges for approval by the Executive Committee of the Medical Staff and the Board of Directors.
- V. Maintenance of Credentials : To maintain credentials, the surgeon must:

- A. Morbidities and mortalities will be reviewed as they are for open surgical procedures. Standard quality improvement measures will be employed as available, consistent with the goals of the Department of Surgery and Section of Vascular Surgery.
- B. Renewal – An appropriate level of continuing clinical activity will be required. This shall be monitored by the department chief with advisory input from the section chief. Renewal shall be granted using the same criteria employed for open procedures.
- C. Denial of privileges – After appropriate documentation, the department chief with advisory input from the section chief, may deny privileges or revoke privileges when he/she believes it appropriate under current privileging guidelines. A surgeon has the right to appeal this decision in accordance with the standard Hartford Hospital appeal process.

Appendix 1

Antegrade common femoral puncture selective vessel ordering

First Order Family	Second Order Family	Third Order Family or beyond
Superficial femoral artery		Anterior tibial artery Posterior tibial artery Peroneal artery Tibioperoneal trunk artery
Deep femoral artery	Lateral circumflex artery Medial circumflex artery	
Retrograde common femoral puncture selective vessel ordering		
First Order Family	Second Order Family	Third Order Family or beyond
Innominate Artery	Right common carotid artery Right subclavian/axillary artery	Right internal carotid artery Right external carotid artery Right vertebral artery Right internal mammary artery
Left Common Carotid Artery	Left internal carotid artery Left External carotid artery	
Left subclavian/axillary artery Celiac axis artery Superior mesenteric artery Ipsilateral hypogastric artery	Left vertebral artery Left brachial artery, proximal to profunda Left internal mammary artery	Left brachial artery, distal to profunda
Contralateral common iliac femoral artery	Contralateral external iliac artery Contralateral internal iliac artery	Contralateral common artery Contralateral superficial femoral artery Contralateral profunda artery Distal branches of above Contralateral superior
	gluteal artery Artery	Contralateral ileolumbar artery

APPENDIX
II
GUIDELINES FOR CAROTID ARTERY STENTING
PRIVILEGES

Hartford Hospital Guidelines For Granting Carotid Artery Stenting Privileges

Preamble: The purpose of these guidelines is to establish criteria for Carotid Artery Stenting privileges and ensure optimal patient outcome by credentialed competent physicians.

I. Principles of Carotid Artery Stenting (CAS) Privileging

A. INTRODUCTION

1. Background

The current incidence of stroke in Europe and the U.S.A. is about 200 per 100,000 people per annum. Eighty percent of strokes are ischemic and 20% are due to hemorrhage. Approximately half of the patients with ischemic stroke have carotid stenosis and about one third (10% of all stroke victims) have no warning symptoms, such as transient ischemic attacks (TIA). Clinical symptoms in atherosclerotic carotid artery stenosis are caused by embolic disease in more than 80% of patients, and in less than 20% by hemodynamic impairment of cerebral circulation.

2. Carotid Endarterectomy (CEA)

Surgical carotid endarterectomy has been shown to be a standard of care and has been widely applied as a means to prevent stroke in appropriately selected patients. The surgical repair of stenotic or ulcerated lesions at the cervical carotid bifurcation appeared to be a logical and practical approach to prevent stroke. Two randomized trials of patients with symptomatic carotid stenosis demonstrated common notable features. First, carotid endarterectomy provided significant protection against ipsilateral stroke in patients with high-grade (>70%) symptomatic stenosis compared to the non-surgical groups in these trials, receiving "best medical care" including aspirin. Second, an acceptable level of surgical morbidity and mortality was achieved. These studies, and subsequent guidelines developed by the American Heart Association concluded that patients with symptomatic high-grade carotid stenosis and reasonable surgical risk should have carotid endarterectomy.

3. Angioplasty

Balloon and Stent-assisted angioplasty is established as a safe, effective method for treatment of atherosclerotic stenosis in other circulatory beds. Depending on the specific circulation and clinical circumstance, it vies with surgical endarterectomy, or bypass as an optimal treatment method.

While PTA of atherosclerotic stenotic vessels is an established form of treatment in other circulatory beds, many physicians considered the risks of cerebral artery embolism and thrombosis unacceptable. Therefore, techniques to prevent cerebral embolization during manipulation of ulcerated plaques were developed.

4. Stenting

In 1989, a stent was placed for the first time in the carotid artery when the control angiogram revealed an intimal flap after PTA and an improvement of the PTA result became necessary. The procedure was well tolerated. Carotid artery stenting represents a

challenging procedure in the treatment of extra-cranial cerebrovascular disease. However, compared with endarterectomy, carotid stenting could offer the following advantages:

- morbidity and mortality could be reduced in patients who have severe coexisting disease (e.g. coronary artery disease: CAD)
- treatment need not be restricted to the cervical segment of the carotid artery
- general anesthesia is not required
- cranial nerve palsies are not sequelae
- the technique can be safely applied to restenotic lesions, and
- simultaneous procedures can be done on carotid, vertebral, and coronary arteries.

To date, over 2000 endovascular carotid stent procedures have been performed worldwide with a reported technical success rate of 98.6%. In appropriately selected patients, the peri-procedural risks for major and minor strokes and death are comparable to endarterectomy, and stenting is being seen as an alternative to surgery.

Carotid Artery Stenting is a new procedure for the treatment of patients with carotid artery disease requiring highly skilled physicians. As such, Hartford Hospital has set out to provide optimal patient safety and care in the application of privileges for CAS.

B. PURPOSE

The purpose of this statement is to delineate the specific requirements a physician must fulfill to be granted and maintain privileges to perform CAS at Hartford Hospital. The guidelines are in accordance with the general principles set forth by the Joint Commission on Accreditation of Healthcare Organization's (JCAHO) guidelines for granting hospital privileges. JCAHO states that privileging criteria must be consistent throughout the hospital regardless of physician or department. These guidelines have been developed to ensure that CAS is performed in a manner assuring high quality patient care. The criteria set forth may be modified by accepted hospital procedures, potentially impacting the credentialing status of current and future credentialed physicians.

C. UNIFORMITY OF STANDARDS

These standards will apply to all physicians in all departments/divisions who desire to perform CAS. The initial step in obtaining privileges requires approval first from the CAS committee. The CAS committee will recommend or not recommend approval of privileges to that practitioner's department chief. In keeping with current Hartford Hospital practices, in which the department chief, with advisory input from the section chief, will remain responsible for overseeing and approving privileges, applying these guidelines in the assessment of physicians requesting privileges to perform CAS. In addition, the department chief may institute other requirements and regulations they deem necessary to improve patient care.

D. RESPONSIBILITY FOR PRIVILEGING

The privileging for CAS shall follow the current guidelines of obtaining privileges for new procedures at Hartford Hospital. Delineated privileges for

active and courtesy staff will be reviewed biennially by the department director according to the Bylaws of the Medical Staff of Hartford Hospital ARTICLE III, Section 10, Par. 1-3. Any disputes over delineation of privileges will be resolved by the procedure stated in the Bylaws of the Medical Staff of Hartford Hospital ARTICLE III, Section 10, Par.4-7. (Attachment #1)

E. DEFINITIONS

DOCUMENTED MEDICAL TRAINING– A physician must be board certified or board eligible in his/her area of expertise. Current hospital guidelines and privileging processes will ensure these criteria are being met.

A physician who becomes credentialed may be required to have his first 5 cases supervised at the discretion of the committee. This would most likely be applied when a physician newly enters the community with prior experience.

PRIVILEGING - The process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by Hartford Hospital based on evaluation of the individual's credentials and performance.

COMPETENCE OR COMPETENCY - A determination of an individual's capability to perform up to defined expectations.

CREDENTIALS - Documented evidence of licensure, education, training, experience, or other qualifications.

II. REQUIREMENTS FOR GRANTING PRIVILEGES

A. FORMAL RESIDENCY TRAINING

Prerequisite training must include satisfactory completion of an accredited residency program in radiology, vascular surgery, cardiology, neurosurgery, or neurology. Eventual board certification by the appropriate certifying body is required. When necessary, the department chief with advisory input from the section chief shall obtain and review documentation of training, e.g. procedure logs.

B. FORMAL TRAINING IN CAS

For candidates who successfully completed a residency and/or fellowship program that incorporated a structured experience in CAS, the applicant's program director, and if desired, other faculty members, should supply the appropriate documentation of training to the department or division chief.

If this documentation meets Hartford Hospital guidelines for recommending privileges for CAS, The CAS (Carotid Artery Stenting) Committee shall be the official body that recommends approval/disapproval to the respective department chief. The department chief, with advisory input from the section chief may recommend privileges for CAS to the Medical Staff Executive Committee and subsequently to the Board of Directors at Hartford Hospital

The voting members of the CAS Committee shall be the representatives from Vascular Surgery, Radiology, Cardiology and Neurology. The Director of the Department of Surgery shall have oversight of this committee. A simple majority will constitute approval or denial of privileges. In the event of a tie, the Department of Surgery Director shall cast the deciding vote.

C. PRACTICAL EXPERIENCE

The Carotid Artery Stenting committee shall review the following before recommending CAS privileges for approval by respective department chief.

1. Applicant's Experience – Demonstrate appropriate didactic training and skills in the area of CAS for which privileges are requested. Documented experience that includes an appropriate volume of cases in the CAS procedure for which privileges are being considered.
2. Review formal CME accredited course experience for CAS.
3. Experience with Preceptor and/or Proctor –

The CAS committee has determined that any physician requesting CAS privileges must have documented 40 primary operator carotid angiograms and 20 primary operator CAS procedures. Once a physician is given CAS privileges, he/she may perform the procedure for which they have privileges and for which CAS is appropriate. However, the Clinical Events Committee (CEC) will continue to monitor physician's privileges using the Quality Improvement (Q/I) Protocol in this document.

APPLICATION PROCESS: Individual requests for privileges shall be presented to the primary Department Chairman who will then forward appropriate applications to the CAS Committee. The request is reviewed by the CAS who will return its recommendation to that Department Chairman.

D. CAS COMMITTEE

The Carotid Artery Stenting committee shall maintain a registry of credentialed individuals. The committee is comprised of representation from the Division of Vascular Surgery, Department of Radiology, Department of Cardiology, Department of Neurology, and Division of Neurosurgery. The Chief of Surgery will have oversight of the committee. Additional departmental/divisional representation on the committee will occur as deemed necessary by the CAS Committee to meet the clinical demands within the hospital.

The CAS Committee shall be the official body that recommends approval to the respective clinical chief. The clinical chief then will tender privileges for CAS if he deems it appropriate.

E. FOLLOW-UP

Department and division chiefs shall enforce all current practices that monitor a physician's proficiency. Morbidities and mortalities will be monitored for CAS procedures as they are for open surgical procedures. Standard quality assurance measures will be employed, and department and division chiefs are

required to develop tools to measure outcomes of CAS procedures. As for all CAS procedures, it is the responsibility of the department chief with advisory input from the section chief to ensure that a high level of patient care is being provided.

IV. MAINTENANCE OF PRIVILEGES

A. MONITORING OF PERFORMANCE

Once privileges have been granted, performance should be monitored through existing quality assurance mechanisms at the institution. These mechanisms may be modified as appropriate, and should evaluate outcomes, as well as competency in the complete procedural conduct. This process shall be monitored by department and division chiefs.

B. RENEWAL

An appropriate level of continuing clinical activity should be required. This shall be monitored by the department chief with advisory input from the section chief.

C. DENIAL OF PRIVILEGES

After appropriate documentation, the respective department chief with advisory input from the section chief may deny privileges or revoke privileges when he/she believes it appropriate under current privileging guidelines. A physician has the right to appeal this decision in accordance with the standard Hartford Hospital appeal process.

However, any applicant for CAS privileges must agree to abide by the STOPPING RULE and the Quality Improvement guidelines as stated in Sections V and Appendix A, respectively. The applicant agrees to surrender his/her privileges in accordance of the STOPPING RULE and Quality Improvement guidelines.

V. STOPPING RULE

There will be stopping rules based on the two times rule using the Goldman formula*. The Goldman formula is used to identify an unacceptable number of incidences of adverse events occurring, taking into consideration the practitioner's level of experience. The performance of CAS procedures by a specific physician should be halted if the number of adverse events is equal to or more than the number of adverse events deemed acceptable for a given number of patients stented (see Appendix B).

Endpoint = any death/stroke/MI at 30
days post procedure = Adverse Event:

alpha = 0.05

beta = 0.20

pi0 = 6.3%

piA = 12.6%

**pi0 is the low value (pooled SAPPHIRE 30-day death/stroke/MI).
piA is the highest boundary (2 times SAPPHIRE)**

For the initiation of CAS at Hartford Hospital, the standardized data from the SAPPHIRE trial will be utilized. As soon as the comparable data from Hartford's CEA control population can be calculated (standard of care within the community) then that data will be used to benchmark the STOPPING RULE.

If, at any time, the CAS physician exceeds the acceptable number of adverse events per level of experience as set for by the Goldman formula, the physician will voluntarily stop performing CAS and submit to review by the CEC and QI protocol. The CAS physician will not perform any new CAS procedures until a review by the CEC is completed. If a physician knowingly performs CAS while under the STOPPING RULE, this will be considered an immediate 2nd violation, also subject to the CEC review.

VI. Patient Selection

A. The Food and Drug Administration (FDA) has given approval to selected indications for the use of CAS. These indications may evolve as more scientific data is presented to the FDA. The applicant agrees to maintain and document these indications during the performance of CAS.

B. The currently approved inclusion criteria for CAS are:

Patients who are at high risk* for carotid endarterectomy (CEA) and who also have symptomatic carotid artery stenosis $\geq 70\%$.

*Patients at high risk for CEA are defined as having significant comorbidities and/or anatomic risk factor (i.e. recurrent stenosis and/or previous radical neck dissection), and would be poor candidates for CEA in the opinion of a surgeon experienced in the performance of carotid endarterectomy. Significant comorbid conditions include, but are not limited to:

- ◆ Congestive heart failure (CHF) class III/IV
- ◆ Left ventricular ejection fraction (LVEF) < 30%
- ◆ Unstable angina
- ◆ Contra-lateral carotid occlusion
- ◆ Recent myocardial infarction (MI)
- ◆ Previous CEA with recurrent stenosis
- ◆ Prior radiation to the neck
- ◆ Other conditions that were used to determine patients at high risk for CEA in the prior carotid artery stenting trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH and MAVERIC II.

C. Each patient being considered for stenting will be reviewed by a neurologist during the Vascular Pre-op Conference. A Neurological clinical examination will be performed pre- and post-procedure. In an urgent situation, when review of the case in this forum is not possible, a formal neurology consult will be made.

D. Variance from standard patient selection will be monitored by the QI process and reviewed by the Clinical Events Committee (CEC).

VII. Adverse Event (AE)

A. At each treatment, the CAS physician will determine whether any adverse events (AEs)* have occurred. For the purpose of this protocol, an adverse event is any undesirable clinical occurrence in a subject that can be attributed to the device, or procedure.

Mild: Awareness of a sign or symptom that does not interfere with the patient's usual activity, or a more severe sign or symptom that is transient, resolved without treatment and with no sequelae;

Moderate: Interferes with the patient's usual activity; lasts beyond the patient's hospitalization, or necessitating greater than usual care at disposition

Severe: Any fatal or immediately life-threatening clinical experience that requires a subject to be hospitalized, or hospitalization is unduly prolonged because of potential disability or danger to life or because an intervention has been necessitated. This includes any permanently disabling event.

VIII. Clinical Protocol

A. All patients will be clinically followed post-procedure through discharge and 30 days. At twelve (12) months, a telephone follow-up will be conducted. A summary of the evaluations is presented in the following table.

Event/Time	Pre - Tx	Post - Tx	14-30 days	12 months
Neurologic Exam Modified Rankin Assess NIH Stroke Scale	X	X	X	X
Clinical Events (AEs)* and Medication Regimen		X	X	X
EKG/Enzymes	X	X	X EKG only	
Head CT or MR	X	Symptomatic only		
Ultrasound/Duplex	X		X	X

Any data from post-procedure angiography or ultrasounds that are done as standard of care will be collected and included in the dataset.

- See the IFU for a complete list of anticipated adverse events. If a patient has signs or symptoms of an MI within 30 days of the index procedure, cardiac enzymes and an EKG will be obtained and reported.
- ** If otherwise not contraindicated

B. Follow-up Period – Post-Procedure through Discharge

Neurologic Examination: A neurologic examination will be performed post-procedure (at discharge) by an independent neurologist. Stroke scale examination (NIH and Rankin stroke scale quantitative assessments) will only be performed if the patient has evidence of a stroke on neurologic exam.

Clinical Events: Clinical event tracking will continue after completion of the procedure through discharge. Clinical events are outcomes which include: death, clinical evidence of any stroke, myocardial infarction, need for carotid endarterectomy of the target vessel, stent thrombosis, need for blood transfusion, or need for follow-up re-intervention of the target vessel within the given timeframe. All patients will have cardiac enzymes and EKG pre- and post-treatment and an EKG at 14-30 days post treatment.

C. Follow-up Period - 30 days (+ 14 days window)

- Neurologic Examination. A neurologic examination will be performed 30 days (+ 14 days window) post-procedure by an independent neurologist.
- Clinical Events. Clinical event tracking will continue after discharge through 30 days post-procedure. Clinical events are outcomes that include: death, clinical evidence of any stroke, myocardial infarction, need for carotid endarterectomy of the target vessel, stent thrombosis, or need for follow-up re-intervention of the target vessel within the given timeframe. If a patient has signs or symptoms of an MI within 30 days of the index procedure, cardiac enzymes and an EKG will be obtained and reported on the CRF.
- Ultrasound/Duplex will be performed pre-treatment and at 30 days post-treatment.

D. Follow-up Period – 12 months (+ 1 month window) (Neurology Contact)

The following procedures/evaluations will be performed 12 months (+ 1 month window) post-procedure:

- Clinical Events. Clinical event tracking will continue through 12 months post-procedure. Clinical events are outcomes that include: death, clinical evidence of any ipsilateral stroke, myocardial infarction, need for carotid endarterectomy of the target vessel, stent thrombosis, or need for follow-up reintervention of the target vessel within the 12-month follow-up interval.

E. Case Review

- A formal case review process will be established to discuss urgent and non-urgent cases. This review will be included in the Vascular Pre-Op Conference held every Friday at 6:45 AM in Bliss 775. Non-urgent cases will be presented pre-procedure at this forum. Patients can be placed on the agenda by contacting Dr. James

Gallagher, Chief, Division of Vascular Surgery or his designee. Urgent cases will require mandatory neurology input and an informed opinion from another committee member from a different department, either vascular surgery, cardiology, radiology or neurosurgery agreeing to indication and appropriateness of the carotid stent procedure.

Initially, all cases will be reviewed pre and post procedure. All complications must be reviewed.

IX. CLINICAL EVENTS COMMITTEE

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The Clinical Events Committee (CEC) will consist of five physicians: cardiologist, vascular surgeon and interventional radiologist, neurologist, and an interventional neuroradiologist. The CEC is charged with the development of specific criteria used for the categorization of major clinical events. The CEC will establish rules outlining the minimum amount of data required, and the algorithm followed in order to classify a clinical event. All members of the CEC will meet regularly to review and adjudicate all major clinical events. All appropriate data will be adjudicated by the CEC. The CEC will also review and rule on all deaths that occur throughout the hospital from CAS. The CEC will also initiate referral to the Q/I committee for any violation of CAS procedures.

POLICY ON QUALITY IMPROVEMENT PROTOCOLS

The health care teams, groups of physicians and/or the collaborative management team may formulate protocols for similar clinical care processes from time to time (referred to herein as "Quality Improvement Protocols", or "Protocols"). The care processes chosen for Protocols may often be those that are high volume procedures or are procedures which have high risk of complications, which are currently reported in Mortality and Morbidity Conferences. The Protocols will be based on available data, including designated performance benchmarks. In order to assure continuous quality improvement and enhance patient care, data on outcome for these clinical care processes shall be collected and maintained, and where appropriate, the Protocols will be modified accordingly.

During the introduction of a new procedure such as CAS, there may be expected or unexpected Adverse Events. Honest reporting of such events is essential to safe and optimal patient care. As a new procedure, CAS will need to meet peer review standards set by the CEA data in the community. Therefore, application of the STOPPING RULE and Q/I protocol is essential to maintaining optimal and safe patient care.

All practitioners are expected to conform to any Quality Improvement Protocol adopted by their Departments. It is recognized that certain Protocols may not affect the outcomes as hoped for, or where members fail to adhere to them, the effectiveness of the outcome of the Protocol may not be evaluated. Nevertheless, the following steps are intended to address the reporting of complications included in Protocols, and to deal with failure to conform to the Protocols. They are an integral part of the Department's peer review process for members of the Department. Primary source materials prepared and statements made pursuant to this document shall be treated as peer review material.

Administrative steps for reporting complications resulting from care processes:

Complications that must be reported as morbidities include both the occurrence of defined complications and failure to conform to a quality improvement protocol that provides specific steps to be followed if those defined complications occur. Complications in either category shall be discussed at the Mortality and Morbidity Conferences (Departmental and Divisional) and follow the Peer Review/Quality Management algorithm (attached).

Administrative steps for failure to comply with quality improvement protocols.

Complications in the form of failures to conform to a Protocol and reportable complications related to the same Protocol (which violations and reportable complications are collectively referred to here as "Protocol Violations") and shall be reported as set forth in the preceding paragraph. Repeated Protocol Violations shall be addressed in accordance with the steps below, with the intention of focusing on changes in behavior because, in contrast to a complication that is a single event, further violations indicate volitional behavior, which can be changed thus enhancing the likelihood that the quality improvement protocol can favorably effect outcomes.

1. If a practitioner has a second Protocol Violation, the CEC will provide the practitioner with data comparing his/her performance with averages taken from the database and other benchmarks, if available. If the individual's data show significant variance from the benchmarks, a written explanation and corrective action plan shall be prepared by the individual and presented to the CEC. When the plan is acceptable in form and substance to the CEC, this written plan will be placed in the practitioner's file in his respective department's office to be maintained as peer review material.

2. If a practitioner has a third Protocol Violation within two months after the second Protocol Violation, or has three Protocol Violations in one year, the CEC shall require the individual to prepare a second written report for the CEC explaining why such departures continued. The CEC shall discuss the prepared report and, at the conclusion of the discussion, require the practitioner to create a corrective plan which will be placed, along with the second written report, in the individual's file in his respective department's office, to be maintained as peer review material.
3. If a practitioner has a fourth Protocol Violation at any time, the practitioner shall prepare a report for his respective chairman, to be reviewed with the CEC, explaining why such departures continued. The Director will meet with the practitioner to discuss the report and require the practitioner to create a corrective plan which will be placed along with the third written report, in the individual's file in his respective department's office, to be maintained as peer review material.
4. If after two additional months from the filing of a report called for under paragraph 3, the practitioner does not show significant improvement in the areas designated for improvement in the corrective plan, the practitioner must arrange for supervision in all cases for two months, and his/her privileges shall be qualified accordingly by the CEC. This supervision requirement shall be reported to the Medical Staff Office. A supervisory physician from outside his/her department who has CAS privileges will be chosen by the CEC. Outcomes will be reported by the supervising physician(s) to the Director, Department of Surgery at the expiration of such two month period. The supervision requirement will be removed and reported to the Medical Staff Office if the practitioner has demonstrated the ability to comply with the protocol. If outcomes have not improved, the next step will apply.
5. If the cases managed by the individual continue to experience morbidities in excess of the indicated benchmarks, and the excess is in the opinion of the CEC attributable to the performance of the affected individual, the Director of the Department shall propose corrective action to the affected individual, which may include, without limitation or modification, suspension or termination of privileges. If the individual and the CEC are not able to reach agreement as to the indicated corrective action, then the CEC shall pursue such procedures and remedies under the Bylaws of the Medical Staff as he or she may deem appropriate.

Nothing in this Policy shall limit or otherwise qualify the prerogative of the Department or Division Director, or any other proper person, from pursuing disciplinary action under the Medical Staff By-laws or rejecting a request for reappointment of a practitioner who is subject to the terms hereof.

Attachment #1 Section 10 HH Bylaws:
Section 10. Reappointments.

Par. 1. All Active, Courtesy, Consulting and University of Connecticut Affiliated Staffs shall request reappointment annually in writing to the Directors of the Departments in which they serve on forms provided by the Medical Staff Office. Department Directors shall recommend reappointment with privilege delineation as appropriate. Biennially, the Department Director shall reappraise and document the member's performance before making recommendations for reappointment and delineation of privileges, taking into account the qualifications for membership set forth in ARTICLE II, Section 1, together with recommendations of such member's peers. The applicant for reappointment or renewal of privileges shall submit reasonable evidence of current ability to perform privileges requested that may be requested by the Executive Committee of the Medical Staff. Department Directors shall take into consideration requests for a change in Staff status (other than Promotions) for adequate cause, which requests shall be submitted in writing by the member seeking change in status prior to annual reappointment time. Such written

request shall be submitted by the Department Director to the Executive Committee of the Medical Staff along with his/her recommendation regarding reappointment.

Par. 2. All members of the Active and Courtesy Staffs shall submit on an annual basis at reappointment time, proof of appropriate malpractice insurance coverage, evidence of current licensure by the State of Connecticut, the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital, and such other information as may be required for the Director of the Department to make his/her recommendations and together with such information as would be reportable under Article III Section 13 Par 1 but not theretofore reported to the Hospital, provided nothing herein shall be construed as a qualification on the final sentence of that Paragraph. Each member seeking reappointment shall certify that except as otherwise indicated, he or she has not been under expulsion from participation and otherwise has not been sanctioned under any Federal (United States) health care program, whether pursuant to the provisions of section 1128 et. seq. of the Social Security Act (42 U.S.C. 1320a-7) or the provisions of any other law of like effect.

Par. 3. A Department Director may delegate the reappraisal function of Department members requesting reappointment to another person such as division director, or assistant director, etc. The delegated person shall make recommendations to the Director, who in turn shall submit his/her recommendations for reappointment, or otherwise to the Executive Committee of the Medical Staff.

Par. 4. In the event that the Department Director is of the opinion that the request for reappointment should be denied or privileges limited from those requested, and mutual agreement for continuing practice in the Hospital cannot be reached, the Department Director shall present the case to the Department Executive Committee, or its equivalent, for consideration, with the requesting member present, if such member so desires. The Department Executive Committee shall thereafter present its written recommendation to the Department Director, who shall then forward to the Executive Committee of the Medical Staff the request, any supporting documentation relating to the request or the recommendations relating to the request, the recommendation of the Department Executive Committee, and a covering letter setting forth the recommendation of the Department Director, which may be contrary to the recommendation of the Department Executive Committee.

Par. 5. The request for reappointment and privilege delineation shall be acted upon by the Executive Committee of the Medical Staff after consideration of the recommendation of the Department Director and, if applicable, the recommendation of the Department Executive Committee.

Par. 6. Department Directors shall make nominations for reappointment to the University of Connecticut Affiliated Staff, Consulting Staff, Teaching Affiliate Staff and Adjunct Staff within their respective Departments.

Par. 7. The Executive Committee of the Medical Staff shall review each nomination or request for reappointment and privileges and shall recommend either approval or denial of such nomination or request. Such recommendations of the Executive Committee of the Medical Staff shall be forwarded directly to the Board of Directors for action. In the event the Board of Directors denies or limits any such nomination or request for reappointment or privileges, such denial shall be deemed a final action on an application for membership in the Medical Staff under Par. 12 of Section 2 of ARTICLE II hereof. The member whose nomination or request is so denied (the "affected member") shall be notified as provided in Par. 12 of Section 2 of ARTICLE II and shall have the right to be heard as provided in Par. 13 of Section 2 of ARTICLE II. In addition to any other Credentials Committee rules then in effect, the following procedures shall apply with respect to the affected member's appearance before the Credentials Committee under Par. 13 of Section 2 of ARTICLE II:

- a) An accurate record of the hearing shall be kept. The mechanism shall be established by the Credentials Committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription, or by the taking of adequate minutes. A copy of such record and a copy of each exhibit, written memorandum, or other documentary evidence filed with or considered by the Credentials Committee in connection with such hearing shall be included with the Credentials Committee's recommendation to the Executive Committee of the Medical Staff and with the Executive Committee of the Medical Staff's recommendation to the Board of Directors through the Joint Conference Committee.
- b) The personal presence of the affected member for whom the hearing has been scheduled shall be required. A member who fails without good cause as determined by the Credentials Committee to appear and proceed at the hearing shall be deemed to constitute voluntary acceptance of the decision of the Board of Directors denying the member's request for reappointment.
- c) The affected member shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of the Hartford County Medical Association.
- d) The Chair of the Credentials Committee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
- e) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The participants shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.
- f) The Director of the Department (or his/her designee) in which the affected member serves shall represent the Department at the hearing as a participant.
- g) The participants shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the affected member does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.
- h) Neither the participants nor the Credentials Committee shall be represented or accompanied at any phase of the hearing procedure by an attorney at law unless the Credentials Committee, in its discretion, permits representation by counsel. If the Credentials Committee elects to permit representation by counsel it may, nevertheless, restrict the role or limit the conduct of such counsel during the hearing. The foregoing shall not be deemed to deprive the parties or the Credentials Committee of the right to legal counsel in connection with preparation for the hearing or for a possible appeal.
- i) The Credentials Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Credentials Committee may thereupon, at a time convenient to itself but within 30 days after the hearing is closed, conduct and conclude its deliberations outside the presence of the member for whom the hearing was convened, provided, however, the Credentials Committee may reopen the hearing within such thirty day period for the purpose of obtaining clarification, consultation or new evidence, and the running of the thirty day period shall be suspended while such hearing is reopened.

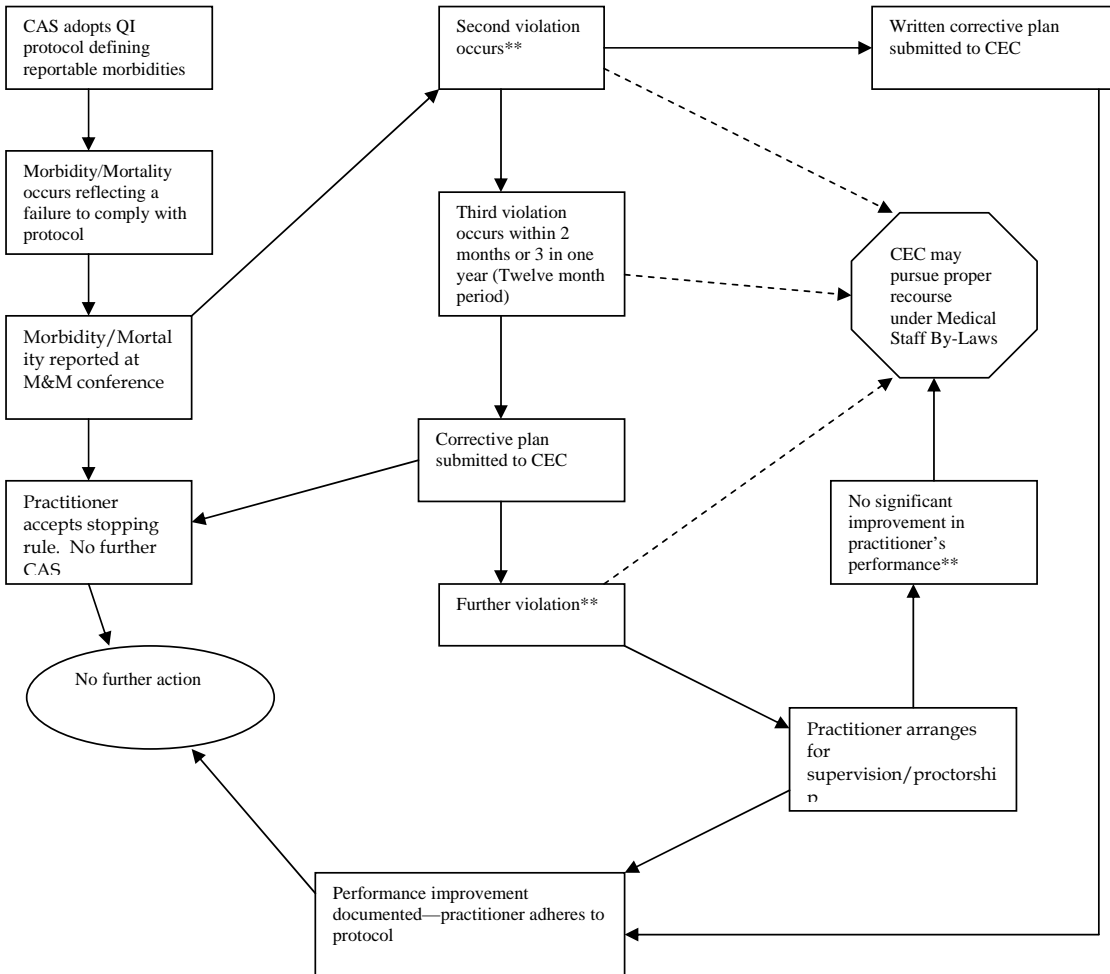
Par. 8. Recommendations for reappointment of members of the House Staff shall be initiated by the directors of their departments to the Senior Vice President (or Vice President) of Education, who will forward the recommendation to the Executive Committee of the Medical Staff for final action.

QUALITY IMPROVEMENT PROTOCOLS

**Director may pursue proper recourse under Medical Staff By-Laws at any time

July 2005

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APPENDIX B

# events	# patients	% of patients
5	14	35.7%
6	25	24.0%
7	36	19.4%
8	47	17.0%
9	58	15.5%
10	69	14.5%
11	80	13.8%
12	91	13.2%
13	102	12.7%
14	113	12.4%
15	124	12.1%
16	135	11.9%
17	146	11.6%
18	157	11.5%
19	168	11.3%
20	179	11.2%
21	190	11.1%
22	201	10.9%
23	212	10.8%
24	223	10.8%
25	234	10.7%
26	245	10.6%
27	256	10.5%
28	267	10.5%
29	277	10.5%
30	288	10.4%
31	299	10.4%
32	310	10.3%
33	321	10.3%
34	332	10.2%
35	343	10.2%
36	354	10.2%
37	365	10.1%
38	376	10.1%
39	387	10.1%
40	398	10.1%

41	409	10.0%
42	420	10.0%

APPENDIX
III
DIVISION OF SURGICAL ONCOLOGY

RULES AND REGULATIONS OF THE DIVISION OF SURGICAL ONCOLOGY
DEPARTMENT OF SURGERY, HARTFORD HOSPITAL

ARTICLE I
NAME

Section 1

Par. 1 The name of the Organization is "The Division of Surgical Oncology of The Department of Surgery"

ARTICLE II
MISSION

Section 1

Par. 1. The mission of the Division of Surgical Oncology is to develop Surgical Oncology Programs at Hartford Hospital which promote an authentic, multidisciplinary approach to cancer including Radiation Therapy, Medical Oncology, and the Surgical Treatment of Cancer. We strive to conduct cutting edge clinical care, research and provide educational opportunities for physicians, allied personnel, patients and family members.

ARTICLE III
GOALS

Section 1

Par. 1. The goals of The Division of Surgical Oncology will be achieved in conjunction with Radiation Oncology, Medical Oncology and Members of the Helen and Harry Gray Cancer Center. These goals include, but are not limited to; standardization of patient care, quality management, data management, education, and participation in surgical research.

ARTICLE IV
DIVISION CHIEF

Section 1

Par 1. The Division Chief will be appointed by the Director of the Department of Surgery with input from the Membership of the Division.

Par. 2. The Division Chief may appoint an associate chief with the advice and consent of the majority of the division, who will assume the duties of the Chief in his/her absence.

ARTICLE V
MEMBERSHIP - STRUCTURE

Section 1

Par. 1. Membership of The Division of Surgical Oncology includes those Members of the active staff in the Department of Surgery whose major field of interest is Surgical Oncology. Board Certification and Board Eligibility by The American College of Surgeons is required. Board Certification must be completed within 5 years of eligibility for membership to be maintained. Re-certification is required for maintenance of membership.

Par. 2. The Division of Surgical Oncology will be divided, but not limited to the following Sections; 1) Colon and Rectal Cancers: 2) Liver, Biliary, Pancreatic, and Upper GI Malignancies: 3) Head and Neck Tumors, Sarcomas and Melanomas: 4) Breast Cancer: 5) Thoracic Malignancies.

Par. 3. Each Section will have a Section Head appointed by the Director of Surgery and the Division Chief. The Section Head should have additional Fellowship Training in their area of expertise.

Par. 4. Each Department Member can join one or more of the Specialty Group Sections as mentioned in Paragraph 2.

Par. 5. All Members are expected to attend meetings and participate in other education and service obligations of the Sections of the Division as well as those outlined in the Department of Surgery Bylaws.

Par.6. Continuation of Membership in the various Sections in Paragraph 2 will be under the discretion of the Director of The Department of Surgery, the Division Chief, and the Section Head.

