Department Rules and Regulations
of the Medical Staff - SURGERY
of
Providence Saint John's Health Center

Surgery

Sections
Outpatient Surgery
Anesthesia Section
Pediatric Surgery
Peer Review
Call Panel

Department of Surgery

Sections: The Department of Surgery shall be organized into the following sections:

a. Anesthesiology
b. General Surgery
c. Neurological Surgery
d. Ophthalmology
e. Oral and Maxillofacial Surgery
f. Orthopaedic and Spine Surgery
g. Otolaryngology
h. Pathology
i. Plastic Surgery
j. Podiatry
k. Radiation Oncology
l. Radiology (including Neurointerventional Radiology)
m. Robotic Surgery
n. Spine Surgery
o. Thoracic and Cardiac Surgery
p. Urology
q. Vascular Surgery

Outpatient Surgery

a. Physicians who admit patients for approved surgery under general, regional, or spinal / epidural anesthesia, or for surgery which is associated with significant risks (Category I) shall complete all medical records prior to performance of the procedure which are ordinarily required for inpatient surgery.
b. The physician who admits a patient for approved minor surgery under local anesthesia (Category II) shall complete a brief report to the performance of the procedure, of the pertinent and important medical history and physical findings, and also record the diagnosis, orders, and a description of the operative procedure.
c. The attending physician shall be responsible for completing informed consents for surgery for all patients prior to outpatient surgery, as required for inpatient surgery.
d. Any consultation required for an inpatient shall be required for a Category I surgery outpatient (pediatric consultation, etc.).
e. An anesthesiologist shall perform and record pre- and post-operative evaluations for each outpatient who has a general, regional, or spinal / epidural anesthetic (Category I) and, when indicated, for those who have minor procedures under local anesthetics (Category II).
f. Prior to commencing surgery, the surgeon or proceduralist shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record:
    1. A medical history and physical examination performed and recorded at least 30 days prior to surgery but updated prior to surgery.
    2. Appropriate screening tests, based on the needs of the patient, accomplished and recorded prior to surgery.
    3. An informed consent, in writing, for contemplated surgical procedure.
g. In all cases, except emergency cases in which this is not possible, prior to the induction of anesthesia, the anesthesiologist shall valuate the patient, explain the anesthetic choices to the patient, and establish and discuss the anesthesia plan with the patient; then, document this information on the patient's medical record prior to the induction of anesthesia.

h. During the conduct of surgery and anesthesia, the patient's anesthesiologist is responsible for the safe and proper administration of anesthetic agents, the maintenance of airway and respiration, the monitoring of vital functions, and the administration of blood products and parenteral fluids.
i. The anesthesiologist shall record, in the medical record, all significant events taking place during the induction of, maintenance of, and emergence from anesthesia, including the vital signs and amount and duration of all anesthetic agents, intravenous fluids, and blood or blood products.
j. An anesthesiologist within 48 hours after anesthesia end time shall document in the medical record their findings and the presence or absence of anesthesia-related complications.
k. The Medical Director of Anesthesiology Services, or a member of the Anesthesiology Section designated by the Medical Director, assigns anesthesiologists to surgical cases and to the obstetrical service, considering the special qualifications of the anesthesiologists and the most efficient and effective use of personnel and facilities.
l. A limited supply of narcotics and dangerous drugs for emergency use may be issued to an anesthesiologist. The anesthesiologist must account for the use of all such drugs, and they are responsible for their security; they must be under their immediate surveillance or in an appropriate locked container. Narcotics and dangerous drugs shall not be left unattended on an anesthetic cart or tray or in unlocked drawers or containers.
m. The anesthesiologist shall maintain anesthesia equipment so that it is clean and safe, and they shall check the readiness, availability and cleanliness of all anesthetic equipment and supplies prior to the administration of anesthetic agents.
n. Anesthesiologists shall have their anesthesia machines inspected by a competent serviceman at least annually, and on each occasion shall submit a written report of inspection and correction of any deficiencies to the supervisor of Surgery.
o. No items, except those required for safe and effective patient care, shall be kept in or on an anesthesia machine or introduced into an operating room by an anesthesiologist.
p. The anesthesiologist monitors each patient who is receiving general anesthesia with a pulse oximeter.

Pediatric Surgery

a. Surgical procedures for infants (those under the age of three years), may be performed in the surgical suites if the following conditions are met:
    1. When the patient is younger than one month of age, a neonatologist must be present in the operating suite;
    2. The surgical procedure must not require postoperative intensive care services beyond those available in the Neonatal Intensive Care Unit (NICU).

Peer Review

The Surgical Services Review Committee (SSRC) shall conduct a review of all surgical cases referred consistent with the Medical Staff Peer Review/Performance Improvement Plan. .The Committee shall report to the Surgery Committee.

Call Panel

a. All practitioners are obligated to participate in their Section's general call panel.
b. Surgeons may be excused if they can document that they have solely subspecialized their practice during the past five years, or for other reasons that the Department of Surgery deems acceptable. Examples would include orthopaedic surgeons who have restricted their practice to spine surgery, or general surgeons who have limited their practice to breast or other general surgery subspecialties.
c. Plastic Surgery Call Panel
    i. Plastic Surgeons who are Board Certified in *Surgery of the Hand* by the American Board of Plastic Surgery will automatically qualify for hand surgery privileges and are required to participate in the Hand Call Panel for 10 years after board certification.
    ii. Surgery of the Hand – certified Plastic Surgeons who were board certified greater than 10 years ago are not obligated to participate in the Hand Call Panel.

iii. Proctoring

1. Plastic and/or Hand Surgeons may participate on the Call Panel prior to completion of proctoring. Concurrent proctoring is required for surgical care.

d. Call Panel Service: Provisional Staff in any surgical specialty may take emergency call however, proctoring when possible, must continue simultaneously on emergency and elective cases.