Colon and rectal surgery is the medical specialty dedicated to the treatment of patients with diseases and disorders affecting the colon, rectum, and anus. Colon and rectal surgeons (also known as colorectal surgeons) acquire proficiency in general surgery as well as in the medical and surgical management of diseases of the intestinal tract, anal canal, and perianal area.

They also acquire special skills in the performance of endoscopic procedures of the rectum and colon and evaluation of the anal sphincter and pelvic floor using anorectal physiology techniques. Colon and rectal surgical residency programs now provide training in minimally invasive abdominal surgery involving the colon and rectum.

Colon and rectal surgeons manage conditions such as colon and rectal cancer, polyps, inflammatory bowel disease, diverticulitis, pelvic floor abnormalities, as well as anal conditions such as hemorrhoids, fissures, abscesses, and fistulas. Training also provides specialists with the knowledge to treat problems such as constipation and incontinence.

Surgeons who specialize in colon and rectal surgery must complete a minimum of five years of an Accreditation Council for Graduate Medical Education (ACGME)–accredited program in general surgery. They must then complete a one-year ACGME-accredited residency program in colorectal surgery. Osteopathic physicians may complete a two-year proctologic surgery program, following the completion of an American Osteopathic Association (AOA)-approved internship. Colorectal surgeons are certified by the American Board of Colon and Rectal Surgery (ABCRS) or the American Osteopathic Board of Proctology (AOBPR).

Some general surgeons who have not completed an ACGME-accredited residency program in colorectal surgery may specialize in colon and rectal surgery based on equivalent training and experience.

**Involved specialties**

General surgeons, colorectal surgeons

**Positions of specialty boards**

The ABCRS awards certificates to candidates who fulfill its requirements to practice the specialty of colon and rectal surgery.

*ABCRS*

In order to become certified, candidates must:
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- Complete an ACGME-accredited residency program in colon and rectal surgery following completion of an approved ACGME or Royal College of Physicians and Surgeons of Canada general surgical residency program that leads to American Board of Surgery (ABS) certification
- Have a currently valid registered full and unrestricted license to practice medicine in a state, territory, or possession of the United States or a Canadian province and continue to be licensed throughout the certification process
- Successfully complete the qualifying examination of the ABS before being admitted to the ABCRS written examination
- Achieve certification by the ABS before being admitted to the ABCRS oral examination

To achieve certification by the ABCRS, candidates must pass a written and oral examination. The candidate is required to pass the written exam before being permitted to take the oral exam.

Beginning with candidates who passed the certifying examination in 1990 and thereafter, the ABCRS will issue time-limited certificates that will be valid for 10 years from the date of certification. Time-limited certification does not affect diplomates holding certificates issued prior to 1990.

AOBPR/AOA

The AOBPR grants certification for osteopathic physicians. To become certified in proctology, at a minimum candidates must:
- Be a graduate of an AOA-accredited college of osteopathic medicine
- Hold an unrestricted license to practice in a state or territory
- Show evidence of conformity to the AOA Code of Ethics
- Be a member in good standing of the AOA or the Canadian Osteopathic Association for the two years immediately prior to the date of certification
- Complete a colorectal/proctology fellowship

Positions of societies, academies, colleges, and associations

SAGES, ASGE, ASCRS

In 2002, the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), the American Society for Gastrointestinal Endoscopy (ASGE), and the American Society of Colon and Rectal Surgeons (ASCRS) jointly prepared and endorsed the consensus statement Principles of Privileging and Credentialing for Endoscopy and Colonoscopy.

The statement says that physicians requesting privileges or credentials to perform esophagogastroduodenoscopy (EGD) and
Colonoscopy should demonstrate prior proficiency performing these procedures. Residency program directors, chiefs of service, or other members of the teaching faculty should provide documentation that they have directly observed the applicant performing endoscopy.

Individuals applying for EGD and colonoscopy privileges should demonstrate satisfactory completion of an ACGME-accredited training program in adult or pediatric gastroenterology, general surgery, colorectal surgery, or pediatric surgery.

A program director, prior credentialing or privileging committee, or teaching faculty should attest that the applicant is competent to perform these techniques. Applicants who are applying for similar procedures at another facility or renewing privileges at the same facility should provide a statement of competency by his or her chief of service.

Facilities should develop uniform standards that apply to all hospital staff requesting privileges to perform endoscopy and to all healthcare facilities where endoscopy is performed. They should establish medically sound criteria that are applicable to all candidates who want to obtain privileges in each specific endoscopic procedure. High-quality patient care is the goal.

Facilities should grant privileges separately for each major category of endoscopy. Performing one endoscopic procedure does not indicate that the applicant is competent to perform another. Associated skills that are considered an essential part of an endoscopic category may be required before privileges for that category can be granted.

The ACGME has mandated that programs in surgery and gastroenterology must provide residents with experience performing EGD and colonoscopy.

Equivalent training and/or experience obtained outside a formal program is recognized but must be at least equal to the training and experience that applicants obtain in surgery and gastroenterology programs. Experience certification by a skilled endoscopic practitioner must include a detailed description of the nature of informal training, the number of procedures performed with and without supervision, and actual observed competency for each endoscopic procedure that the applicant would like privileges to perform. It is not acceptable for physicians to
obtain equivalent endoscopic experience performing unsupervised procedures when the medical community has a skilled endoscopist who is available.

Self-training in new techniques in gastrointestinal endoscopy must take place on a foundation of basic endoscopic skills. The endoscopist should recognize when additional training is necessary.

A qualified, unbiased staff endoscopist may proctor applicants for privileges in gastrointestinal endoscopy, specifically when competency for a given procedure cannot be verified adequately by submitted written material.

The credentialing body of the healthcare facility should develop and provide the applicant with the procedural details of proctoring. Proctors may be chosen from existing endoscopy staff or solicited from endoscopic societies.

A mechanism to monitor an applicant’s procedural performance should be in place to help credentialing teams with ongoing renewal of privileges. This can be accomplished using existing quality assurance mechanisms or a multidisciplinary endoscopy committee. This should include monitoring endoscopic utilization, diagnostic and therapeutic benefits to patients, complications, and tissue review in accordance with previously developed criteria.

Continuing medical education related to endoscopy should be required in order to renew endoscopic privileges. Participating in local, national, or international meetings and courses is encouraged.

In order to renew privileges, continuing clinical activity and performance monitoring should be required.

ACGME ACGME publishes *Program Requirements for Graduate Medical Education in Colon and Rectal Surgery* (effective July 1, 2007). In the document, ACGME states that institutions offering residencies in colon and rectal surgery must provide the necessary education to qualify the resident as a colon and rectal specialist in the care of patients, in teaching, and in research.

Surgeons admitted to each residency are required to have completed a minimum of five years of an accredited, graded
program in general surgery. Resident training in colon and rectal surgery must be one year, and the program must comply with the institutional requirements for residency training.

In regard to patient care, ACGME states that residents in a colon and rectal surgery program will have training in both diagnostic and therapeutic colonoscopy. The objective is to develop the necessary competence in the use of this procedure to qualify as an expert in the field.

Residents will also develop skills in patient evaluation, examination, office treatment, and surgical aftercare. Where feasible, training should include work in the faculty member’s office as well as in the outpatient clinic of the hospital.

Residents must also have the opportunity to be responsible for patients with anorectal and colonic diseases.

In regard to medical knowledge, residents will obtain sufficient knowledge of those aspects of anesthesiology, radiology, and pathology that relate to colon and rectal surgery to develop overall competence as a specialist. This training is best accomplished in cooperation with the departments of anesthesiology, radiology, and pathology.

According to the AOA, proctology is a specialty that focuses on the study of diseases and conditions that originate within the anus, rectum, and colon as well as perianal and perirectal areas and related or complicating conditions.

Candidates applying to proctology training programs should:

➤ Graduate from an AOA-approved college of osteopathic medicine
➤ Complete an AOA-approved internship
➤ Have current licensure as a physician in the state(s) where the training program and clinical site(s) are located
➤ Be members of the AOA and maintain that membership throughout the residency program

The AOA states that training in proctologic surgery is two years, following completion of an AOA-approved internship. The AOA states that residents should be provided with the ability to perform a minimum of 500 cases per year with at least 200 cases of documented endoscopy, including flexible sigmoidoscopy and colonoscopy.
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The clinical component must include education and exposure to diagnostic and therapeutic methods, such as laser, ultrasound, endoscopy, and other leading-edge technologies.

The program must provide clinical learning and experience in the preoperative, operative, and postoperative learning and surgical experience for patients with all proctology diseases, including:

➤ Sclerotherapy for internal hemorrhoids
➤ Rubberband ligation for internal hemorrhoids
➤ Infrared coagulation for internal hemorrhoids
➤ Cauterization of anal fissure
➤ Incision and drainage of perianal, ischiorectal, and pilonidal abscesses
➤ Electrocautery of perianal warts
➤ Excision of perianal skin tags
➤ Flexible sigmoidoscopy
➤ Anoscopy

At the hospital, candidates should obtain experience with:

➤ Colonoscopy with multiple procedures
➤ Flexible sigmoidoscopy
➤ Hemorrhoidectomy
➤ Fissurectomy/sphincterectomy
➤ Excision of pilonidal cyst with or without perianal lesions
➤ Incision and drainage of perianal/ischiorectal abscesses

Positions of accreditation bodies

CMS has no formal position concerning the delineation of privileges for colon and rectal surgery. However, CMS’ Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

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

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment
The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

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

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

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

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

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

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected.
The resultant privilege recommendations to the governing body are based on the assessment of the data.

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

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

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

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

➤ The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
➤ Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and
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临床技能、临床判断、人际技能、沟通技能及专业主义

- 一张特定的挑战或关心列表，由组织的医学人员在推荐特权之前必须评估
  (MS.06.01.05, EP 9)
- 一个过程来确定是否有足够的临床表现信息来决定特权
- 一个决定（行动）在完成申请权利的时期内由组织的医疗人员制定
- 信息有关任何改变医疗人员临床特权，更新他们发生时

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

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

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

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

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

HFAP

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

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

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

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

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

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

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.
Det Norske Veritas (DNV) has no formal position concerning the delineation of privileges for colon and rectal surgery. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

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

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

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

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

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

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

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

Minimum threshold criteria for requesting core privileges in colon and rectal surgery

Basic education: MD or DO

Minimal formal training: Applicants must be able to demonstrate completion of an ACGME-/AOA-accredited training program in general surgery, followed by completion of an accredited program in colon and rectal surgery, and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in colon and rectal surgery by the ABCRS or the AOBPR.

Required current experience: At least 50 colon and rectal surgery procedures, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

References

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program.

Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges in colon and rectal surgery

Core privileges in colon and rectal surgery include the ability to admit, evaluate, diagnose, treat, and provide consultation to patients of all ages presenting with diseases, injuries, and disorders of the intestinal tract, colon, rectum, anal canal, and perianal areas by medical and surgical means, including intestinal disease involved with other organs and tissues (such as the liver, urinary, and female reproductive systems). Physicians may provide care to patients in the intensive care setting in conformance with unit policies. Privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.
The core privileges in this specialty include the following procedures and procedures that are extensions of the same techniques and skills:

- Performance of history and physical
- Appendectomy as related to colon rectal surgery
- Excision of rectal lesion
- Incision, drainage, and debridement of perirectal abscess
- Incision/excision of pilonidal cyst
- IV access procedures, central venous catheter
- Repair of perforated viscus (gastric, small intestine, large intestine)

Anorectal procedures:

- Excisional hemorrhoidectomy (conventional, procedure for prolapse and hemorrhoids)
- Fistulotomy
- Endorectal advancement flap
- Sphincteroplasty
- Internal sphincterotomy

Abdominal procedures:

- Strictureplasty
- Segmental colectomy (includes ileocolic resection)
- Laparoscopic resections
- Low anterior resection (straight anastomosis, with colon pouch or coloplasty)
- Abdominoperineal resection
- Transanal excision
- Protocolectomy (with ileostomy, with ileoanal reservoir, stapled anastomosis, hand sewn, either ileal pouch-anal anastomosis [IPAA] or coloanal, with/without reservoir)
- Prolapse repair (abdominal, perineal)
- Stomas (parastomal hernia, stenosis retraction prolapse, fistula)
- Total pelvic dissections (rectal cancer, abdominal perineal resection, low anterior resection, coloanal, proctocolectomy, IPAA)

Endoscopy/pelvic floor:

- Proctoscopy/anoscopy
- Colonoscopy (diagnostic, with polypectomy)
- Endorectal ultrasound/endoanal ultrasound
- Pelvic floor evaluation
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Medical management and treatment:
➤ Anorectal (anal fissure, anal fistula, hemorrhoids, pelvic floor, constipation, incontinence)
➤ Abdominal (carcinoma of the rectum, Crohn’s disease, diverticular disease, FAP/Gardner’s syndrome, prolapse, ulcerative colitis, intra-abdominal trauma, including observation, paracentesis, lavage)

Special requests in colon and rectal surgery

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

Noncore privileges include:
➤ Use of laser
➤ Use of robotic-assisted system for oncologic procedures (gastric cancer, colon cancer, thymoma, and retromediastinal tumors)
➤ Administration of sedation and analgesia

Reappointment

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

Applicants must demonstrate current competence and an adequate volume of experience in at least 50 colon and rectal procedures, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to colon and rectal surgery as well as gastrointestinal endoscopy should be required.

For more information

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Colon and rectal surgery

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American Osteopathic Association
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American Osteopathic Board of Proctology
3520 Guion Road, Suite 307
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American Society for Gastrointestinal Endoscopy
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American Society of Colon and Rectal Surgeons
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Centers for Medicare & Medicaid Services
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DNV Healthcare, Inc.
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Colon and rectal surgery

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