Pediatric urology

Background

Pediatric urology is the subspecialty of urology that is concerned with the diagnosis, management, and treatment of genitourinary and adrenal abnormalities and diseases in both males and females, from birth through adolescence.

The urinary tract consists of the organs that filter the blood and form urine (i.e., kidneys), the tubes that carry urine from the kidneys (i.e., ureters), the organ that stores urine (i.e., bladder), and the tube that carries urine from the bladder and removes it from the body (i.e., urethra). Pediatric urologists treat urological problems such as urinary tract infections, undescended testicles, circumcisions, and kidney cancer. Other conditions include:

- Abnormally located urethral opening (hypospadias)
- Backup of urine from the bladder into the ureter (vesicoureteral reflux)
- Bedwetting (nocturnal enuresis)
- Distention of the kidney in utero (antenatal hydronephrosis)
- Ureteropelvic junction obstruction that may cause kidney damage

Following graduation from medical school, pediatric urologists complete an approved residency in urology, followed by a one-year fellowship in pediatric urology, according to the Accreditation Council for Graduate Medical Education (ACGME). A pediatric urology program can be provided only in conjunction with an ACGME-accredited urology residency program.

The American Board of Medical Specialties approved pediatric urology as a subspecialty of urology in 2006, and subspecialty certification in pediatric urology through the American Board of Urology (ABU) began in 2008 for those urologists whose practice is 75% pediatric urology.

Involved specialties

Pediatric urologists

Positions of specialty boards

**ABU**

Applicants approved by the ABU to enter the process of subspecialty certification in pediatric urology must be engaged in the active practice of urology, must hold a current unrestricted general certificate in urology issued by the ABU, and
must meet the requirements for pediatric urology subspecialty certification outlined below.

Domains of pediatric urology education include the following areas with relation to diagnosis, management, treatment, and prevention of pediatric urologic disorders and promotion of health:

➤ Ethics and professionalism
➤ Genetics
➤ Endocrinology
➤ Renal disease
➤ Urinary infection and management
➤ Fetal, perinatal, congenital, child, and adolescent genitourinary abnormalities and diseases
➤ Congenital and acquired neurologic diseases affecting the urinary tract and urodynamics
➤ Imaging: diagnostic, interventional, and therapeutic
➤ Pathology
➤ Pain management
➤ Developmental anatomy and physiology
➤ Trauma
➤ Calculus disease
➤ Operative techniques: open surgery, endoscopy, laparoscopy, robotic

An applicant may initiate application for subspecialty certification in pediatric urology by the ABU during the application period after completing at least 24 months in a pediatric urology training program consisting of:

➤ An ACGME-approved pediatric urology residency program (minimum of 12 months) that includes training in the domains of pediatric urology; and
➤ At least 12 additional months of training or scholarly work applicable to pediatric urology that may include the study of epidemiology, clinical trials, biostatistics, clinical outcomes, health services, and/or other forms of basic and clinical research in pediatric urology. This additional year of training may be devoted to research, clinical work, or any combination of the two.

Positions of societies, academies, colleges, and associations

**AAP**

The American Academy of Pediatrics (AAP) does not publish guidelines regarding the delineation of clinical privileges, competency, or training for pediatric urology. However, the AAP states that qualified pediatric urologists must devote a minimum of 50% of their practice to the urologic problems of infants, children, and adolescents and must have completed the following:

➤ At least four years of medical school
➤ One year of surgical internship
At least three additional years of residency training in general urology
At least one additional year of fellowship training in pediatric urology

SPU

The Society for Pediatric Urology (SPU) does not publish guidelines regarding the delineation of clinical privileges, competency, or training for pediatric urologists. However, it offers multiple membership types based on the level of a physician’s pediatric urology practice. Active membership in SPU is open to urologists who have an interest in pediatric urology, have membership in either the American Urological Association (AUA) or the Royal College of Physicians and Surgeons of Canada (RCPSC), and provide evidence of ABU or RCPSC certification, along with evidence of training and an active interest in the field of pediatric urology. Requirements for active membership include:

- Completed application, including one SPU sponsor member and two SPU endorsing members
- Operative case log (list of cases from immediate past 24 months)
- Current CV

Pediatric urologists, urologists, and physicians with an interest in the field of pediatric urology who do not qualify as active members may be eligible for membership as corresponding, affiliate, candidate, senior, or honorary members.

AUA

The AUA publishes a statement, *Delineation of Privileges for Staff Urologists*, in which it recommends that physicians receive board certification within four years of completion of their residency training.

ACGME

Following successful completion of a urology residency program accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada, fellows may enter a one-year pediatric urology clinical program.

In its *Program Requirements for Graduate Medical Education in Pediatric Urology*, the ACGME states that with regard to patient care, fellows are expected to have experience in:

- The surgical aspects of pediatric urology that are documented in an accurate, comprehensive, operative log maintained by the fellow and reviewed by the program director quarterly. All operative procedures in which the pediatric urology fellow acts as a surgeon or teaching assistant should be separately documented.
- Imaging modalities used in the care of pediatric patients, including but not limited to ultrasonography, fluoroscopy, CT, MRI, and nuclear scintigraphy.
Pediatric urology

Practice area 100

➤ Inpatient and outpatient consultations requiring management of pediatric urologic disease, with graded responsibility for patient carePerformance and evaluation of urodynamic studies
➤ Multidisciplinary management of patients with urologic tumors
➤ Multidisciplinary management of patients with urologic trauma
➤ Multidisciplinary management of nephrological and endocrinologic (adrenal) disease
➤ Pre- and postoperative management and treatment of severely ill neonates, children, and adolescents with genitourinary problems who require intensive medical care (i.e., neonatal or pediatric ICU management)
➤ Multidisciplinary management of myelomeningocele and other neuropathic bladder entities
➤ Multidisciplinary management of patients with problems relating to sexual development and medical aspects of intersex states
➤ Performance of prenatal and postnatal genetic counseling for genitourinary tract anomalies
➤ Management of genitourinary infections

With regard to medical knowledge, the ACGME states that fellows are expected to have core knowledge in pediatric urology as detailed in the curriculum, and also demonstrate specialty-specific additional knowledge in fetal and perinatal nephrology, endocrinology, radiation safety, appropriate pain management, chronic renal diseases, and pharmacology of commonly used drugs and chemicals.

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for pediatric urology. 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/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

The Joint Commission

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

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

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

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

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

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

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).
In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

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

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

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

**HFAP**

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

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

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

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

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

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

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

**DNV**

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

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

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

➤ The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements

➤ Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status

➤ Fair hearing and appeal

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

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

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

**CRC draft criteria**

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

**Minimum threshold criteria for requesting core privileges in pediatric urology**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME–accredited residency in urology, followed by successful completion of an accredited fellowship in pediatric urology and/or current subspecialty certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in pediatric urology by the ABU.

**Required current experience:** At least 50 pediatric urological procedures, reflective of the scope of privileges requested, during the past 12 months or successful completion of an ACGME-accredited 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 pediatric urology**

Core privileges for pediatric urology include the ability to admit, evaluate, diagnose, and provide consultation and treatment to patients 2 years of age and older with congenital anomalies, childhood-acquired urologic problems, such as tumors and trauma, and overlapping problems of adolescence. 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. Core privileges include the procedures in the following procedures list and other procedures that are extensions of the same techniques and skills:

- Performance of history and physical exam
- Anterior pelvic exenteration
- Appendectomy as a component of a urologic procedure
- Bowel resection as a component of a urologic procedure
- Closure evisceration
- Continent reservoirs
- Enterostomy as a component of a urologic procedure
- Inguinal herniorrhaphy as related to a urologic operation
- Intestinal conduit
- Surgery of the lymphatic system, including lymph node dissection (inguinal, retroperitoneal, or pelvic), excision of retroperitoneal cyst or tumor, and exploration of retroperitoneum
- Management of congenital anomalies of the genitourinary tract, including epispadias and hypospadias
- Open stone surgery on kidney, ureter, or bladder
- Percutaneous aspiration or tube insertion
- Performance and evaluation of urodynamic studies
- Surgery of the testicle, scrotum, epididymis, and vas deferens, including biopsy, excision, and reduction of testicular torsion, orchiopexy, orchietomy, epididymectomy, and repair of injury
- Surgery of the adrenal gland, including adrenalectomy and excision of adrenal lesions
- Surgery of the kidney, including total or partial nephrectomy (including radical transthoracic approach), renal surgery through established nephrostomy or pyelostomy, and open renal biopsy
- Surgery of the penis, including circumcision, penis repair for benign or malignant disease (including grafting), and excision or biopsy of penile lesions
- Surgery of the ureter and renal pelvis, including uterolysis, insertion/removal of ureteral stent, and ureterocele repair (open or endoscopic)
- Surgery of the urethra, including treatment of urethral valves (open and endoscopic), urethral fistula repair (all forms, including grafting), urethral suspension procedures (including grafting, all material types), visual urethrotomy, sphincter prosthesis, and periurethral injections (e.g., collagen)
- Surgery of the urinary bladder for benign or malignant disease, including partial resection, complete resection, diverticulectomy and reconstruction, bladder instillation treatments, cystolithotomy, total or simple cystectomy, creation of neobladders, repair of bladder injury, and bladder neck suspension
- Surgery of the prostate, including transrectal ultrasound-guided and other biopsy techniques
- Ventral/flank herniorrhaphy as related to urologic operation
Pediatric urology

Practice area 100

➤ Endourology/stone disease
➤ Extracorporeal shock wave lithotripsy
➤ Endoscopic surgery
➤ Laparoscopic surgery (urologic, for diseases of the urinary tract)
➤ Laparotomy for diagnostic or exploratory purposes (urologic-related conditions)
➤ Cystoscopy
➤ Percutaneous nephrolithotripsy
➤ Transurethral surgery, including resection of prostate and bladder tumors
➤ Transvesical ureterolithotomy
➤ Ureteroscopy, including treatment of all benign and malignant processes
➤ Urethroscopy, including treatment for all benign and malignant processes
➤ Reconstructive surgery
➤ Plastic and reconstructive procedures on ureter, bladder and urethra, genitalia, and kidney
➤ Reconstructive procedures on external male genitalia requiring prosthetic implants or foreign materials
➤ Other plastic and reconstructive procedures on external genitalia

Special noncore privileges in pediatric urology

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
➤ Laparoscopic nephrectomy
➤ Sacral nerve stimulation for urinary control
➤ Kidney transplant surgery
➤ Use of robotic-assisted system for urological procedures (cystectomy, pyeloplasty, nephrectomy, pelvic lymph node dissection, ureteral reimplantation, and resection of bladder neoplasm)

Reappointment

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

Applicants in pediatric urology must be able to demonstrate current competence and an adequate volume of experience (100 pediatric urological procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to pediatric urology should be required.
For more information

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