Gynecological laparoscopic surgery

Background

Gynecologic laparoscopic surgery is a minimally invasive surgical technique that allows surgeons to make a few tiny incisions rather than a large incision through the skin and underlying muscles. In pelvic laparoscopic surgery, the entry ports for surgical instruments are in the groin area and are a half inch or smaller.

Because there is less trauma to the body, recovery is much faster than with traditional open abdominal surgery. Patients also experience less pain, which reduces their hospital stay. Many procedures can be done on an outpatient basis. The risk of infection also decreases because tissues are not exposed as they are in open surgery.

A growing number of gynecologists are now using robotic surgery to perform laparoscopy procedures. Conventional laparoscopic surgery uses 2-D imaging and involves mastering awkward hand movements. Robotic surgery uses 3-D imaging and involves instruments that move just like the surgeon’s wrist. It also eliminates hand tremors and allows a surgeon to sit during surgery, guarding against fatigue.

Gynecologists learn how to perform basic laparoscopic surgery during their residency training. In order to perform advanced laparoscopic surgery, gynecologists can complete a formal fellowship in laparoscopic surgery or attend advanced hands-on training courses. Device manufacturers also provide basic training.

Involved specialties

Gynecologists

Positions of specialty boards

ABOG

According to the American Board of Obstetrics and Gynecology (ABOG), an OB/GYN must successfully complete four years of specialized residency training in areas dealing with preconception health, pregnancy, labor and childbirth, postpartum care, genetics, genetic counseling, and prenatal diagnosis.

After residency, a physician may seek certification from the ABOG. To become board certified, a physician must pass a written test to demonstrate that he or she has obtained the special knowledge and skills required for medical and
surgical care of women. He or she must also pass an oral examination that tests a physician’s skills, knowledge, and ability to treat different conditions. The examiners also review the patients the physician has treated during the past year. Board-certified OB/GYNs may also pursue training and certification in subspecialty areas.

In its 2012 Bulletin for Basic Certification in Obstetrics and Gynecology, the ABOG states that a candidate’s case list must demonstrate sufficient numbers, sufficient breadth, and sufficient depth of clinical experience. The case lists must include 40 office practice patients and a minimum of 20 hospitalized or short-stay gynecological and 20 hospitalized or short-stay obstetrical patients with significant problems.

The list of all hospitalized and short-stay gynecological patients must be prepared in the required format and listed as follows:
1. List all gynecologic patients managed during the same 12-month period.
2. A minimum of 20 gynecological patients is required, and a candidate cannot include more than two patients from any one gynecology category.
3. The preoperative diagnosis should appear for all major and minor surgical procedures. The treatment recorded should include all surgical procedures, as well as primary nonsurgical therapy.
4. “Days in hospital” is the arithmetic difference between date of discharge and date of admission. Specific dates of admission and discharge must not be provided.
5. Group patients together under each separate category, then list any remaining patients who do not fit into the gynecology categories.

The following laparoscopic procedures are listed under Gynecology Categories:
- Diagnostic laparoscopy
- Operative laparoscopy (other than tubal sterilization)

**AOBOG**

According to the American Osteopathic Board of Obstetrics and Gynecology (AOBOG), candidates for obstetrics and gynecology certification must pass two examinations: a written examination and an oral examination.

Certification after June 1, 2002, is time-limited and requires recertification every six years. Certification prior to June 1, 2002, is lifetime and does not require recertification.

**Positions of societies, academies, colleges, and associations**

**AAGL**

The American Association of Gynecologic Laparoscopists (AAGL) offers a Fellowship in Minimally Invasive Gynecologic Surgery. Educational objectives
focus on evidence-based medicine, anatomical principles, instrumentation, operative laparoscopy, and operative hysteroscopy. The fellowship offers in-depth experience using state-of-the-art techniques to treat abnormal uterine bleeding, pelvic pain, myomata, endometriosis, adhesive disease, and pelvic relaxation.

In regard to laparoscopy, the fellow should have an understanding of the principles, advantages, limitations, and complications of diagnostic laparoscopy, including instrumentation for operative laparoscopy, the principles of operative laparoscopy, and the ability to prevent, recognize, and manage problems and complications.

The AAGL states that by the end of the fellowship, the fellow should be competent in the following aspects of patient care and medical knowledge: anatomy, vaginal surgery, diagnostic hysteroscopy, instrumentation for operative hysteroscopy, operative hysteroscopy, complications of hysteroscopy, diagnostic laparoscopy, instrumentation for operative laparoscopy, operative laparoscopy, complications for laparoscopy, minimally invasive hysterectomy, gastrointestinal surgery, urinary tract surgery, reproductive surgery, urogynecology, and gynecologic conditions.

For more details about the educational objectives, visit www.aagl.org/images/file/Preceptors/EducationalObjectivesFinal0511.pdf.

**Positions of subject matter experts**

*Leslie Kardos, MD, San Francisco*

Leslie Kardos, MD, is a clinical instructor at UCSF Medical School. She is also the chief of gynecology and the director of robotic surgery at California Pacific Medical Center. She specializes in minimally invasive robotic procedures and is a member of the Society for Laparoscopic Surgeons.

According to Kardos, it takes approximately 20 procedures per year to become competent. She says surgeons should perform at least two procedures per month to stay proficient.

She notes that laparoscopic surgery is leaning more toward minimally invasive techniques. “In general, the residents are getting less surgery than they should and the attending and faculty are leaning toward robotics.”

Since the FDA approved robotic surgery in 2005, Kardos says that most people learn how to perform robotic techniques after completing an advanced laparoscopic training program. This is a requirement at her institution.
Vadim Morozov, MD, Baltimore

Vadim Morozov, MD, is an assistant professor of obstetrics, gynecology, and reproductive services at the University of Maryland Medical Center. His special interests include minimally invasive gynecological surgery and robotic surgery.

According to Morozov, all residencies are required to provide OB/GYNs with at least basic or minimal laparoscopic education, including surgeries. “The problem is that residency education duty hour restrictions and a very heavy emphasis on obstetrics and high-risk obstetrics make it difficult to find the time to teach residents what they would need to know,” he says.

In order to obtain advanced education in laparoscopy, physicians can either attend a formal fellowship given by the AAGL or take a three- to five-day advanced hands-on training course given by an expert. The disadvantage of a course given by an expert is that the surgeon does not have support when he or she begins performing these procedures after training.

Morozov says device manufacturers also provide training on their specific devices. “[But] they don’t teach you surgical techniques,” he says. “They want to tell you about their products.”

In regard to caseload, Morozov says a surgeon would need at least 20 cases in a year before he or she becomes particularly comfortable with this procedure and probably 15 cases annually to maintain competence.

According to Morozov, the use of single-port or single-incision surgery is an experimental procedure that is new to the field. “It’s not at the level where it should be recommended as routine surgical procedure yet,” he says. “There are no studies; there are only multiple case reports saying that it is feasible.”

Other advances include the popularity of robotic surgery. “I think it’s going to be the way of the future one way or the other,” he says.

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for gynecologic laparoscopic surgery. However, the 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 gynecologic laparoscopic 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 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 gynecologic laparoscopic 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.

**DNV**

DNV has no formal position concerning the delineation of privileges for gynecologic laparoscopic 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, 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 gynecologic laparoscopic surgery.

**Minimum threshold criteria for requesting privileges in gynecologic laparoscopic surgery**

**Basic education:** MD or DO

**Minimal formal training:** The applicant must be able to demonstrate successful completion of an Accreditation Council for Graduate Medical Education– or American Osteopathic Association–accredited residency program in obstetrics and gynecology and certification by the ABOG or the AOBOG. If not taught in residency, the applicant must be able to demonstrate successful completion of an AAGL Fellowship in Minimally Invasive Gynecologic Surgery or completion of a CME course in gynecological laparoscopic surgery. The applicant must also receive hands-on training through a preceptorship or proctorship under the supervision of an experienced gynecological surgeon.

**Required current experience:** The applicant must be able to demonstrate that he or she has performed at least 10 procedures in the past 12 months for each gynecological laparoscopic procedure requested.

**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.

**Reappointment**

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

The applicant must demonstrate that he or she has performed at least 10 procedures in the past year for each gynecological laparoscopic procedure requested.

In addition, continuing education related to gynecologic laparoscopic surgery should be required.

**For more information**

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**American Board of Obstetrics and Gynecology**
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Website: www.cms.hhs.gov

DNV Healthcare, Inc.
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