Surgical oncology

Background

According to the Society of Surgical Oncology (SSO), a surgical oncologist is a well-qualified surgeon who has had additional training and experience in the multidisciplinary approach to the prevention, diagnosis, treatment, and rehabilitation of patients with cancer, and who devotes a major portion of his or her professional practice to these activities and cancer research.

In 2011, the American Board of Medical Specialties (ABMS) and the American Board of Surgery (ABS) approved complex general surgical oncology as a surgical subspecialty. Surgical oncologists who become certified in complex general surgical oncology will manage rare or complex cancer cases, whereas the vast majority of surgical oncology cases will continue to be managed by general surgeons. The first training programs are expected to receive approval in late 2011 or early 2012, with a possible first certification examination in the fall of 2012.

Training requirements are currently being developed by the Accreditation Council for Graduate Medical Education (ACGME). The certificate will be offered to graduates of two-year training programs accredited by the ACGME, following completion of general surgery residency and ABS certification in general surgery.

Currently, the SSO has training requirements outlined for surgical oncology that require residents to complete a minimum of 12 months of clinical training in surgical management of cancer cases. During training, physicians also must perform a minimum of 120 cancer-related operative procedures. Overall, the training program in surgical oncology prepares graduates to interact with other oncologic disciplines (e.g., medical oncology; radiation oncology; surgical pathology; and supportive and rehabilitative care), and to provide a leadership role in the surgical, medical, and lay communities in matters pertaining to cancer.

Some general surgeons may perform procedures related to surgical oncology. For more information on qualifications for general surgeons, please see Clinical Privilege White Paper, Practice area 161—General surgery.

Involved specialties

- Surgical oncologists
Positions of specialty boards

**ABS**

The ABS approved complex general surgical oncology as a surgical subspecialty in 2011. The ABS has not yet published certification requirements for this new specialty. However, according to the ABS, the subspecialty certificate will assess qualifications for the treatment of complex cases typically seen in cancer centers and specialized institutions, while recognizing that the vast majority of surgical oncology cases are, and will continue to be, treated by general surgeons practicing in the community.

The ABS will offer certification to physicians who complete a general surgery residency program followed by a two-year fellowship program in complex general surgical oncology accredited by the ACGME. Candidates must also hold certification in general surgery by the ABS. Requirements for certification in general surgery are:

- A full, valid, and unrestricted license to practice medicine in the United States or Canada
- Successful completion of the General Surgery Qualifying Examination, which requires that individuals have:
  - A minimum of five years of progressive residency education in a general surgery program accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada.
  - Sixty months of training at no more than three residency programs, with the final two years spent in the same program.
  - At least 48 weeks of full-time experience in each residency year.
  - At least 54 months of clinical surgical experience with increasing levels of responsibility over the five years, including no fewer than 42 months devoted to the content areas of general surgery.
  - No more than six months assigned to nonclinical or nonsurgical disciplines during junior years; in addition, no more than 12 months may be allocated to any one surgical specialty other than general surgery.
  - Completed advanced cardiovascular life support, Advanced Trauma Life Support®, and fundamentals of laparoscopic surgery programs.
  - Acted in the capacity of chief resident in general surgery for a 12-month period, with the majority of the 12 months served in the final year. The entire chief resident experience must be devoted to the content areas of general surgery or thoracic surgery, with no more than four months devoted to any one area.
  - A minimum of 750 operative procedures in five years as operating surgeon, including at least 150 operative procedures in the chief resident year. Applicants may count up to 50 cases in which they acted as a teaching assistant toward the 750 total; however, these cases may not count toward the 150 chief resident year cases.
  - A minimum of 25 cases in surgical critical care, with at least one case...
in each of the following seven categories: ventilatory management; bleeding (nontrauma); hemodynamic instability; organ dysfunction/failure; dysrhythmias; invasive line management and monitoring; and parenteral/enteral nutrition.

**AOBS**

The American Osteopathic Board of Surgery (AOBS) does not currently offer certification in surgical oncology.

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

**SSO**

The SSO established program requirements for training in surgical oncology in 2001. Below are the requirements for what a surgical oncology fellowship should provide.

In regard to knowledge, skills, and clinical experience, fellows should gain:

- Clinical and technical skills for providing comprehensive care to cancer patients. An essential component of the fellowship is training in new techniques to produce surgeons capable of providing state-of-the-art surgical care to cancer patients.
- Skills in performing special and unusual operations for patients with complex or recurrent neoplasms.
- Expertise in diagnosis and management of rare or unusual tumors, based on knowledge of the natural history of such cancers.
- Knowledge and experience to determine disease stage and treatment options for individual cancer patients, both at the time of diagnosis and throughout the disease course.
- Broad knowledge of other cancer treatment modalities (including radiotherapy, chemotherapy, immunotherapy, and endocrine therapy). This requires an understanding of the fundamental biology of cancer, clinical pharmacology, tumor immunology, and endocrinology, as well as an understanding of potential complications of multimodality therapy.
- Expertise in the selection of patients for surgical therapy in combination with other forms of cancer treatment, as well as knowledge of the benefits and risks associated with a multidisciplinary approach.
- Expertise in palliative techniques, including proper selection of patients, proper performance of appropriate palliative surgical procedures, and knowledge of nonsurgical palliative treatments.
- Knowledge of tumor biology, carcinogenesis, epidemiology, tumor markers, and tumor pathology.

With respect to cancer research, fellows should have:

- Knowledge to design and implement a prospective database and to conduct clinical cancer research, especially prospective clinical trials.
Surgical oncology

➤ Sufficient familiarity with statistical methods to properly evaluate results of published research studies
➤ Knowledge to guide a trainee or other personnel in laboratory or clinical oncology research
➤ Knowledge of how basic science interfaces with clinical cancer care, to facilitate translational research

In regard to cancer education, fellows should gain:
➤ Educational knowledge and skills to train students and physicians in the multimodality management of cancer patients
➤ Knowledge and skills to train nonphysicians (physician assistants, oncology nurses, enterostomal therapists, etc.) in specialized cancer care
➤ Skills to organize and conduct cancer-related public education programs

Fellows are also expected to acquire leadership skills in oncology, including the development and support of:
➤ Institutional programs relating to cancer, including a tumor registry
➤ Institutional policies regarding cancer programs and problems
➤ Interdisciplinary meetings and discussions on cancer topics, patient care, and oncology research programs
➤ Psychosocial and rehabilitative programs for cancer patients and their families

Clinical training in surgical oncology should require the following:
➤ A minimum of 12 months of clinical training in the surgical management of cancer cases.
➤ Performance of a minimum of 120 cancer-related operative procedures as surgeon or first assistant. Minimum numbers for specific anatomic or disease site categories are as follows:
  - Breast: 20
  - Sentinel node biopsy (for breast cancer): 15
  - Colon or rectal cancer: 10
  - Melanoma: 10
  - Sentinel node biopsy (for melanoma): 5
  - Regional node dissection (any location): 10
  - Head and neck cancer: 5
  - Complex upper gastrointestinal procedures (stomach, pancreas, liver): 15
  - Endocrine tumors: 4
  - Thoracic (lung, esophagus, mediastinum): 3
  - Sarcomas of soft tissue or bone: 5

In addition to gaining the minimum case numbers as described in the list above, the following conditions apply to residents’ clinical training:
➤ Experience in all categories as described above is highly desirable. Adequate operative experience with breast cancer; colon and rectal cancer; melanoma; cancers of the upper gastrointestinal tract (stomach, liver, pancreas);
and sentinel lymph node biopsy and regional node dissection is required.

➤ Surgical experience with endocrine, head and neck, soft tissue or bone, and thoracic cancers is highly desirable. For these disease sites, operative volume for a fellow is considered adequate if minimum numbers are met in three of these four categories.

➤ In addition to open breast procedures, experience with stereotactic and ultrasound-guided breast biopsy is desirable.

Each fellow must gain experience in the surgical management of patients undergoing predominantly medical therapy (no minimum number of cases required), including:

➤ Staging for lymphoproliferative malignancies
➤ Management of distant metastatic disease, including resection
➤ Insertion of indwelling access devices for systemic or regional chemotherapy
➤ Endoscopic procedures of the aerodigestive tract and minimally invasive surgery, particularly as applicable to the staging of cancer

Required nonsurgical experiences for fellows in surgical oncology include:

➤ A minimum of one month dedicated to learning the principles and practice of radiation oncology as related to surgical patients.

➤ A minimum one-month rotation in the surgical pathology department or a documented equivalent exposure.

➤ A minimum of one month dedicated to medical oncology. Fellows should gain experience in evaluating and managing patients receiving chemotherapy, hormonal therapy, and immunotherapy. The training should provide an understanding of the biologic, pharmacologic, and physiologic rationale for each form of therapy, as well as the indications, risks, and benefits of regional and systemic therapy in the adjuvant and advanced disease settings. At least 80% of the time spent in medical oncology should be focused on outpatients, rather than inpatients.

➤ Experience in providing supportive care to cancer patients, including pain management and parenteral and enteral alimentation, as well as rendering emergency surgical care. Fellows should also have an understanding of rehabilitative services in various settings, including reconstructive surgery and rehabilitation after extremity sarcoma surgery, mastectomy, and major head and neck surgery.

Fellows should also be provided with research training, which carries the following requirements:

➤ Clinical research must be included in the training program. Fellows should have opportunities to design and implement clinical protocols, and each fellow should initiate or participate in an investigative project and should be sufficiently familiar with statistical methods to properly evaluate research results.

➤ Each fellow must complete a course on clinical research on human subjects, such as a course approved by the National Institutes of Health Office for Human Research Protections, or an institution-based equivalent. Ethics of
research on human subjects must be included in the curriculum.

➤ Each fellow should have the opportunity to participate in laboratory research. Fellows who desire this experience must have access to basic science research faculty mentors (on- or off-site) and time for such research.

➤ Training in basic methodology for conducting clinical trials (including biostatistics, clinical research design, ethics, and implementation of computerized databases) must be provided.

**The Fellowship Council**

The Fellowship Council has no position concerning fellowship programs specifically for surgical oncology. However, The Fellowship Council publishes training documents regarding surgical subspecialty training. *Guidelines for Fellowship Council Accredited Fellowships in Surgery* provides educational components and competencies required of programs for fellows pursuing additional specialty training beyond general surgery residency. According to these guidelines, fellows must demonstrate competency in six areas at the expected level of a surgery practitioner, and fellowship programs must provide an educational experience for fellows to demonstrate all of the following:

➤ Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

➤ Knowledge of established and evolving issues in biomedical and clinical sciences and application

➤ Practice-based learning and improvement that involves investigation and evaluation of fellows’ own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

➤ Interpersonal and communication skills that result in effective information exchange and teamwork with patients, their families, and other health professionals

➤ Professionalism, as manifested by a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse population

➤ Systems-based practice, as manifested by actions that demonstrate an awareness of and response to the larger context and system of healthcare and effectively call on system resources to provide optimal care

Additionally, The Fellowship Council publishes *Fellowship Council Accreditation Guidelines and Definitions*, which may be relevant to surgical oncologists as it provides specific information regarding the number of cases fellows should perform in the following areas:

➤ Advanced minimally invasive surgery

➤ Hepato-pancreato-biliary

➤ Flexible endoscopy

➤ Advanced thoracic

➤ Advanced colorectal
Position of accreditation bodies and regulatory agencies

CMS

CMS has no formal position concerning the delineation of privileges for surgical oncology. 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 surgical oncology. 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 surgical oncology. 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 surgical oncology. 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 surgical oncology. The core privileges and accompanying procedures 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. It is reasonable for healthcare organizations to modify the core as applicable for the inpatient setting versus the ambulatory setting. 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 surgical oncology**

- **Basic education:** MD or DO
- **Minimum formal training:** Successful completion of an ACGME- or American Osteopathic Association (AOA)–accredited residency in general surgery and comple-
tion of an ACGME-accredited fellowship in complex surgical oncology\textsuperscript{1} or the equivalent in additional postgraduate training or experience in oncological surgery. AND/OR

Current certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in complex surgical oncology by the ABMS.\textsuperscript{2}

**Required current experience:** At least 50 oncological surgical 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 surgical oncology**

Core privileges in surgical oncology include the ability to admit, evaluate, diagnose, treat, and provide consultation to patients of all ages with benign and/or malignant tumors within the head; neck; esophagus; chest; abdomen; and anorectal, alimentary, or renal systems; including the ordering of diagnostic studies and procedures related to oncologic problems. Surgical oncologists may provide care to patients in the intensive care setting in conformance with unit policies. They also should be able 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 procedures on the following procedures list and such other procedures that are extensions of the same techniques and skills:

\begin{itemize}
\item Performance of history and physical exam
\item Surgical management of cancer cases/cancer-related operative procedures for the following specific anatomic or disease site categories:
  \begin{itemize}
  \item Breast (sentinel node biopsy for breast cancer)
  \item Colon or rectal cancer
  \item Melanoma (sentinel node biopsy for melanoma)
  \item Regional node dissection (any location)
  \item Head and neck cancer
  \item Complex upper gastrointestinal procedures (e.g., stomach, pancreas, liver)
  \item Endocrine tumors
  \item Thoracic (e.g., lung, esophagus, mediastinum)
  \end{itemize}
\end{itemize}

\textsuperscript{1} Available 2011/2012

\textsuperscript{2} First certification examination available 2012
Surgical oncology

Practice area 433

- Sarcomas of soft tissue or bone
  ➤ Staging for lymphoproliferative malignancies
  ➤ Management of distant metastatic disease, including resection
  ➤ Insertion of indwelling access devices for systemic or regional chemotherapy
  ➤ Endoscopic procedures of the aerodigestive tract and minimally invasive surgery, particularly as applicable to the staging of cancer

**Non-core privileges in surgical oncology**

Non-core privileges in surgical oncology may be requested individually in addition to the core privileges. These non-core privileges may include the following:

- Use of laser
- Breast cryoablation
- Administration of sedation and analgesia

**Reappointment**

To be eligible to renew privileges in surgical oncology, the applicant must demonstrate competence and an adequate volume of experience (100 oncological surgical 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 surgical oncology should be required.

**For more information**

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**Centers for Medicare & Medicaid Services**

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Surgical oncology

Practice area 433

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Healthcare Facilities Accreditation Program
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The Joint Commission
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