Reconstructive breast surgery

Background

Breast reconstruction is a surgical procedure designed to restore a woman’s breast to its normal shape and size. It’s commonly performed after a patient undergoes a mastectomy following a cancer diagnosis, but it can also be used to repair breasts after a lumpectomy or breast trauma, according to the American Society of Plastic Surgeons (ASPS).

Breast reconstruction can be performed immediately following a mastectomy or after additional breast cancer treatments, such as radiation, are complete. Today physicians perform a number of different types of breast reconstruction procedures. According to the ASPS, procedures fall into two main categories, those that use an artificial implant and those that use the patient’s own tissue to reconstruct the breast, and include the following:

- Implant reconstruction
- Latissimus dorsi flap reconstruction
- Pedicled transverse rectus abdominus myocutaneous flap reconstruction
- Free deep inferior epigastric perforator flap reconstruction
- Superior gluteal artery perforator flap reconstruction
- Inferior gluteal artery perforator flap reconstruction
- Transverse upper gracilis flap reconstruction
- Profunda artery perforator flap reconstruction

These procedures are typically performed in stages during different surgeries. Once a woman has the initial procedure, most will require some type of surgical follow-up to achieve the desired result.

For more information, please see Clinical Privilege White Paper, Plastic surgery—Practice area 157.

Involved specialties

Plastic surgeons, general surgeons, cosmetic surgeons

Positions of specialty boards

ABPS

The American Board of Plastic Surgery (ABPS) offers two educational models for board certification in plastic surgery, the independent model or the integrated
model. Plastic surgery programs can also incorporate both models into one training program.

Candidates for any of the programs must meet set requirements, including:
➤ A foundation of basic surgical science knowledge and experience with basic principles of surgery
➤ Advanced knowledge of specific plastic surgery techniques

In the independent model, the residents complete prerequisite training outside of their plastic surgery residency. During integrated training, residents complete training as part of the same program. A combined or coordinated program allows residents to complete the prerequisite for the general surgery training program at the same institution as the plastic surgery program. However, the combined program will not continue beyond the July 1, 2014, entry date.

Training should allow the individual to grow, and eventually assume complete surgical care responsibilities. Training in plastic surgery must also cover the entire spectrum of plastic surgery. It should include experience in the following areas:
➤ Congenital defects of the head and neck, including clefts of the lip and palate, and craniofacial surgery
➤ Head and neck surgery, including neoplasms of the head, neck, and oropharynx
➤ Craniomaxillofacial trauma, including fractures
➤ Aesthetic (cosmetic) surgery of the head and neck, trunk, and extremities
➤ Plastic surgery of the breast
➤ Surgery of the hand/upper extremity
➤ Plastic surgery of the lower extremities
➤ Plastic surgery of the trunk and genitalia
➤ Burn reconstruction
➤ Microsurgical techniques applicable to plastic surgery
➤ Reconstruction by tissue transfer, including flaps and grafts
➤ Surgery of benign and malignant lesions of the skin and soft tissues

The six years of integrated program training should include appropriate plastic surgery clinical experiences, including:
➤ Alimentary tract surgery
➤ Abdominal surgery
➤ Breast surgery
➤ Emergency medicine
➤ Pediatric surgery
➤ Surgical critical care
➤ Surgical oncology, transplant
➤ Trauma management
➤ Vascular surgery

The ABPS does not publish standards directly related to reconstructive breast surgery.
**ABCS**

The American Board of Cosmetic Surgery (ABCS) offers certification in body, breast, and extremity cosmetic surgery. Applicants must furnish proof of prior board certification by one of the following boards recognized by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association (AOA), or the Royal College of Physicians and Surgeons of Canada (RCPSC):

- Dermatology
- General surgery
- Obstetrics and gynecology
- Ophthalmology, with completion of an oculoplastic fellowship approved by the American Society of Ophthalmic Plastic and Reconstructive Surgery
- Otolaryngology
- Plastic and reconstructive surgery
- The American Board of Oral and Maxillofacial Surgery with an MD degree

Applicants must document case logs including at least 1,000 cosmetic procedures. Logs must illustrate a “depth and breadth” of cases in the area of cosmetic surgery sought. At least 200 cases must be documented in the year prior to application.

The ABCS also awards certification of added qualification (CAQ) in body, breast, and extremity cosmetic surgery. To qualify, a candidate must meet the following requirements:

- Be a diplomate of the ABCS.
- Meet the criteria required for certification by the ABCS and be a diplomate in good standing of the ABCS in facial; dermatologic; or body, breast, and extremity cosmetic surgery.
- Hold a clear and unrestricted medical license and perform his or her surgical procedures in an accredited facility.
- Submit a typed case log documenting at least 100 cosmetic surgical procedures within the category of his or her requested CAQ, and the procedures should be of a sufficient mix to illustrate a depth and breadth of knowledge in the area of certification sought. The cosmetic surgical procedures must have been performed within the three consecutive years preceding the application.
- Submit operative reports containing 100 cosmetic surgical procedures. Fifty of the 100 cosmetic surgical procedures submitted must contain publication quality pre- and postoperative photographs securely attached to the operative reports.
- Complete at least four American Academy of Cosmetic Surgery-sponsored (or deemed equivalent by the ABCS Credentials Committee) surgical workshops in his or her chosen CAQ category within the previous three years.
- Complete a minimum of 100 Category 1 CME hours in cosmetic surgery within the preceding three years of his or her CAQ application.
- Pass a written and oral examination.
The ABCS does not publish standards or training requirements directly related to reconstructive breast surgery.

**ABS**

The American Board of Surgery (ABS) offers certification in general surgery. In order to qualify, a candidate must perform 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 as teaching assistant toward the 750 total; however, these cases may not count toward the 150 chief year cases. The ABS does not publish training requirements specific to reconstructive breast surgery.

**AOBS**

The American Osteopathic Board of Surgery (AOBS) accepts certification for examination for osteopathic physicians who are specializing in general surgery and plastic and reconstructive surgery. Candidates for general surgery must have four years of training in general surgery. Candidates who began training with the required OGME-1R internship year effective in 2008 must have five years of training.

For plastic and reconstructive surgery, the candidate must meet the following training requirements:

➤ Three years of training in general surgery, followed by two years of training in plastic and reconstructive surgery
➤ An AOA-approved and completed residency program in orthopedic surgery
➤ An AOA-approved and completed residency in otolaryngology/facial plastic surgery

Candidates who began their residency training with the required OGME-1R internship year effective in the academic year 2008 must have three years of training in general surgery, followed by two years of training in plastic and reconstructive surgery.

The AOBS does not publish training requirements specific to reconstructive breast surgery.

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

**ASAPS**

The American Society for Aesthetic Plastic Surgery (ASAPS) has developed requirements for a 12-month aesthetic fellowship.

According to the ASAPS, although this fellowship is designed to provide
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advanced education in aesthetic surgery, and 70% of cases should be performed in that area, fellows in the program should not focus solely on cosmetic surgery. Incorporating reconstructive surgery is an asset to the fellowship.

Several breast procedures are included in the fellowship curriculum. However, the ASAPS does not publish requirements specific to reconstructive breast surgery.

**ASPS**

According to the ASPS, credentials are an important indicator of quality and competency. All ASPS member surgeons:

- Must complete at least five years of surgical training with a minimum of two years in plastic surgery
- Are trained and experienced in all plastic surgery procedures, including breast, body, and facial reconstruction
- Operate only in accredited medical facilities
- Adhere to a strict code of ethics
- Fulfill CME requirements
- Are board-certified by ABPS or the RCPSC

According to ASPS, ABPS is an important marker of quality, and plastic surgeons should be eligible for consideration for clinical privileges at all hospitals, clinics, managed healthcare organizations, military service, and third-party payment organizations created and operating within the United States and Canada. Although ASAPS publishes general information relating to reconstructive breast surgery, it does not publish specific training requirements for the procedure.

**ACGME**

The Accreditation Council for Graduate Medical Education (ACGME) publishes *Program Requirements for Graduate Medical Education in Plastic Surgery*. Residency training in plastic surgery must include clinical experiences in a number of areas, including those specifically related to breast reconstruction, such as:

- Plastic surgery of the breast
- Microsurgical techniques applicable to plastic surgery
- Reconstruction by tissue transfer, including flaps and grafts
- Surgery of benign and malignant lesions of the skin and soft tissues

The ACGME also publishes *Program Requirements for Graduate Medical Education in General Surgery*. This document states that a surgery residency program should be five years long. At least 42 months of the program should be spent on clinical assignments in the essential content areas of surgery, which include skin, soft tissues, and breast.

The ACGME does not publish requirements specific to reconstructive breast surgery.
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AOA

The AOA publishes Basic Standards for Residency Training in Surgery and the Surgical Subspecialties. The general surgery residency program should be five years long, during which each resident should document a minimum of 750 major surgical procedures as surgeon or first assistant.

Training should include classroom and clinical experience in diseases or dysfunction of skin and soft tissue, burns, wound care, and breast. Residents must log 25 major cases to complete the program. Logging more than 50 cases in one year is considered excessive by the AOA.

Residents should also gain necessary experience in operative and nonoperative management of trauma, emergency surgery, interventions of surgical scope, and surgical critical care. Fellows must also have 20 cases involving nonoperative trauma to complete the program, and 10 major cases of operative trauma. Experience in plastic and reconstructive surgery is required during training.

The AOA stipulates that for fellowships in plastic and reconstructive surgery, residents must complete three years of concentrated plastic and reconstructive surgery education after successful completion of an AOA-approved program in general surgery, otolaryngology, or orthopedic surgery.

Residents may also choose an integrated program, in which case they must complete six years of plastic and reconstructive surgery education that includes an AOA-approved common surgery OGME-1R year.

Education must include training in musculoskeletal biomechanics, surgical physiology, and anatomy; fluids and electrolytes, shock, and resuscitation; burn therapy, wound healing; pathology, microbiology, immunology, and hematology; nutrition; laser safety; micro lab; facial plating; and advanced rhinoplasty.

Residents should receive clinical learning and experience in the preoperative, intraoperative, and postoperative care of patients in the following categories:

➤ Congenital deformities
➤ Malignancies and benign tumors of the head and neck, skin, and soft tissue
➤ Trauma and acquired deformities of the face, trunk, and lower extremity
➤ Aesthetic procedures
➤ Surgery of the breast
➤ Surgery of the hand
➤ Burns
➤ Microsurgery

By the end of the program, each resident must document participation in a minimum of 900 major surgical procedures as surgeon or assistant, under supervision.
The AOA does not publish a specific number of reconstructive breast procedures required to attain competency.

Positions of subject matter experts

**Jaco Festekjian, MD, FACS**

Los Angeles

Jaco Festekjian, MD, FACS, associate clinical professor at the David Geffen School of Medicine at UCLA, in the Division of Plastic and Reconstructive Surgery, says that most patients who undergo breast reconstruction have had a mastectomy or lumpectomy and there is an asymmetry between the breasts. The majority of practitioners are plastic surgeons, with a small percentage of general surgeons performing the procedure. Festekjian says that he has also heard family practitioners referring to themselves as cosmetic surgeons “dabbling” in breast reconstruction. “I have seen many referrals who [used] ‘cosmetic surgeons’ and ended in disaster,” he says.

A physician performing breast reconstructions should have completed a plastic surgery residency program following medical school, which provides adequate training to perform the procedure, says Festekjian. Medical device companies do offer training to plastic surgeons related to breast reconstruction; however, these courses are run by plastic surgery societies and taught by plastic surgeons.

There are two main types of breast reconstruction. The first uses implants to reconstruct the breast and the second type uses tissue from the patient’s body. To become competent in breast reconstruction, a physician should perform at least 20–30 cases and maintain their skill by performing another 15–20 per year, Festekjian says.

When creating privileges in this area, credentialing staff should also consider whether a physician has microsurgical skills, which are necessary for some breast reconstruction procedures using the patient’s own tissue. This type of microsurgical training can be obtained in a fellowship that follows plastic surgery training, Festekjian says. In addition to plastic surgery skills, a physician should also perform between 15 and 20 of those procedures annually to maintain their skill level.

**Amy Sprole, MD**

Wichita, Kan.

According to Amy Sprole, MD, of the Plastic Surgery Center in Wichita, Kan., board-certified plastic surgeons perform breast reconstruction surgery. In order to be qualified to perform the procedure, a physician should have four years of medical school and five years of surgery education, which should include three
years in general surgery and two years in plastic surgery. The surgeon should also be certified by the ABPS.

A physician will typically perform 100–200 breast reconstructions during the course of residency training in order to become competent in the procedure. While there is no set number of annual cases required to maintain competence, Sprole recommends that a physician perform at least one case each month to stay sharp. To maintain board certification, a physician should follow the maintenance of certification requirements set forth by the ABPS.

Credentialing staff should also consider breast augmentation skills when developing criteria for this privilege, according to Sprole.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for reconstructive breast 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 reconstructive breast 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.”
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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 reconstructive breast 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 reconstructive breast 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 reconstructive breast surgery.

Minimum threshold criteria for requesting privileges in reconstructive breast surgery

Basic education: MD or DO
Minimal formal training: Successful completion of an ACGME- or AOA-accredited residency in plastic surgery or general surgery.
Required current experience: Performance of at least 20 reconstructive breast surgery procedures, reflective of the scope of privileges requested, during 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.

Reappointment

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

Applicants must demonstrate competence by showing evidence that they have successfully performed 40 reconstructive breast surgeries in the past 24 months based on results of ongoing professional practice evaluation and performance monitoring.

In addition, continuing education related to reconstructive breast surgery should be required.

For more information

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American Board of Surgery  
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Website: www.absurgery.org

Accreditation Council for Graduate Medical Education  
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Chicago, IL 60654  
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Website: www.acgme.org

American Osteopathic Board of Surgery  
4764 Fishburg Road  
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American Society of Plastic Surgeons  
444 E. Algonquin Road  
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Reconstructive breast surgery

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