Background

Anesthesiology is the medical specialty dedicated to the relief of pain through the administration of anesthesia. Anesthesiologists are primarily responsible for the safety and well-being of patients before, during, and after surgery, and the longer and more extensive training makes anesthesiologists the most qualified to make anesthesia-related perioperative medical decisions, according to the American Society of Anesthesiologists (ASA). An anesthesiologist generally serves as director of an organization’s anesthesia care team, which is composed of other classifications of anesthesia practitioners.

Anesthesiologists complete four years of medical school followed by a four-year anesthesiology residency program. Many anesthesiologists also complete an additional fellowship year of subspecialty training in specific areas, such as pain management, cardiac anesthesia, pediatric anesthesia, neuroanesthesia, obstetric anesthesia, or critical care medicine, according to ASA.

The American Board of Medical Specialties recognizes critical care medicine, hospice and palliative medicine, pain medicine, pediatric anesthesiology, and sleep medicine as subspecialties of anesthesiology.

In addition to qualified anesthesiologists, accreditation bodies such as The Joint Commission and CMS allow other practitioners with proper training, such as certified registered nurses anesthetists (CRNA), dentists, and oral surgeons, to administer anesthesia in accordance with state law. Requirements for CRNA training and certification are discussed in Clinical Privilege White Paper, Practice area 170—Certified RN anesthetist.

Dentists administer anesthesia in the treatment of their patients, and the degree of anesthesia administered is dependent on the extent of a dentist’s education and training. The American Dental Association (ADA) supports the right of appropriately trained dentists to use sedation and general anesthesia. The ADA notes that only dentists who have completed an advanced education program accredited by the Commission on Dental Accreditation (CODA) are considered educationally qualified to administer deep sedation and general anesthesia, which are beyond the scope of predoctoral and continuing education programs. Dental anesthesiology programs are a minimum of 36 months of full-time formal training, according to CODA.

For more information on other practice areas related to anesthesiology, please see the following Clinical Privilege White Papers:
Practice area 108—Pain medicine
Practice area 117—Sleep medicine
Practice area 129—Critical care medicine
Practice area 170—Certified RN anesthetist
Practice area 193—Pediatric anesthesiology
Practice area 406—Hospice and palliative medicine

Involved specialties
Anesthesiologists

Positions of specialty boards

ABA
The American Board of Anesthesiology (ABA) offers primary certification in anesthesiology, as well as maintenance of certification in anesthesiology, which is required once every 10 years following primary certification. ABA also offers certification in the subspecialties of anesthesiology, including critical care medicine, pain medicine, hospice and palliative medicine, sleep medicine, and pediatric anesthesiology.

According to the ABA’s Booklet of Information, candidates for certification in anesthesiology must meet the following requirements:
➤ Hold an unexpired, unconditional, and unrestricted license to practice medicine or osteopathy in at least one state
➤ Fulfill all of the requirements of the continuum of education in anesthesiology
➤ Achieve a Certificate of Critical Competence
➤ Satisfy all examination requirements
➤ Maintain a professional standing satisfactory to the ABA
➤ Be capable of performing the entire scope of anesthesiology practice independently, without accommodation or with reasonable accommodation

According to the ABA, education in anesthesiology consists of four years of full-time training, which includes a clinical base year followed by three years of approved training in anesthesia. The clinical base year must include at least six months of rotations in internal medicine, pediatrics, surgery or any of the surgical subspecialties, obstetrics and gynecology, neurology, family medicine, or any combination of these areas. At most, one month may involve the administration of anesthesia and one month of pain medicine. Residents should have at least one month, but no more than two months, devoted to both critical care and emergency medicine. Remaining rotations in the 12-month period should be relevant to the practice of anesthesiology.

The three-year clinical anesthesia curriculum (CA1-CA3) following the clinical base year consists of basic anesthesia training, subspecialty anesthesia training,
and advanced anesthesia training. Residents should have at least 12 months of experience in basic anesthesia training within the CA-1 and CA-2 years.

Subspecialty anesthesia training should include subdisciplines such as obstetric anesthesia, pediatric anesthesia, cardiothoracic anesthesia, neuroanesthesia, anesthesia for outpatient surgery, recovery room care, perioperative evaluation, regional anesthesia, and pain medicine. ABA recommends that training in subspecialty anesthesia occur in the CA-1 and CA-2 years.

Required experiences in perioperative care must include four months of distinct rotations in critical care medicine with progressive responsibility, and three months in pain medicine that may include a month each in acute perioperative pain management, assessment and treatment of inpatients and outpatients with chronic pain, and regional analgesia experience in pain medicine.

The CA-3 year should consist of experience in advanced anesthesia training, which should include the more difficult or complex anesthetic procedures and care of the more seriously ill patients. Residents must complete a minimum of six months of advanced anesthesia training, and may spend the remaining months in one to three selected subspecialty rotations or in research. The CA-3 year should require progressively more complex training experiences with increased independence and responsibility.

With regards to research opportunities, the ABA allows residents to spend approximately 25% of training engaged in scholarly activities rather than clinical experience. Residents must be enrolled in an Accreditation Council for Graduate Medical Education (ACGME)–accredited anesthesiology program and remain active in the education component of the program while pursuing research.

The examination for ABA primary certification consists of two parts. Part 1 assesses the candidate’s knowledge of basic and clinical sciences as applied to anesthesiology. Candidates must pass Part 1 to qualify for Part 2 of the examination, and must wait at least six months after passing the Part 1 examination to be eligible for Part 2. Part 2 of the examination assesses the candidate’s ability to manage patients presented in clinical scenarios, with an emphasis on sound judgment in decision-making and management of surgical and anesthetic complications, appropriate application of scientific principles to clinical problems, adaptability to unexpected changes in clinical situations, and logical organization and effective presentation of information.

**AOBA**

The American Osteopathic Board of Anesthesiology (AOBA) certifies osteopathic physicians in the practice of anesthesiology and its subspecialties, which include pain management and critical care medicine.
To be eligible to receive certification through the AOBA, physicians must meet the following requirements:

➤ Graduate from an American Osteopathic Association (AOA)–accredited college of osteopathic medicine
➤ Hold an unrestricted license to practice in a state or territory
➤ Be a member of the AOA in good standing for two years prior to the date of certification
➤ Satisfactorily complete residency training in anesthesiology

Physicians who completed training prior to July 1, 1986, must have completed two years of AOA-approved training. After July 1, 1986, physicians must have completed a minimum of three years of AOA-approved training, after the completion of an AOA-approved internship. As of July 1, 2008, physicians must complete a minimum of four years of formal training in anesthesiology. Training requirements for osteopathic training in anesthesiology are published by the American Osteopathic College of Anesthesiologists (AOCA) and the AOA.

Following the completion of training, residents must pass a written, oral, and clinical examination to achieve certification. The written examination tests residents on the basic science and clinical knowledge, skills, and principles of anesthesiology, and their application. Upon successful completion of the written examination, candidates may sit for the oral examination, which consists of up to 10 topics of a general nature or topic-specific that include information on differential diagnosis, signs and symptoms, anesthetic management, preoperative considerations, postoperative considerations, and other relevant subjects.

To qualify for the clinical examination, candidates must submit a list of anesthetic procedures personally administered by the candidate, as well documentary evidence of any additional specialty training or practice and postgraduate work. The clinical examination may be taken following the successful completion of the written and oral examinations and the completion of one year of clinical practice. The examination consists of medical records review and observed cases.

Positions of societies, academies, colleges, and associations

ASA

ASA publishes numerous statements, guidelines, and standards regarding the practice of anesthesiology, including *Guidelines for Delineation of Clinical Privileges in Anesthesiology*, which was last amended in October 2008. In this document, ASA defines anesthesiology as the practice of medicine, and notes that clinical privileges in anesthesiology are granted to physicians qualified by training. ASA recommends that physicians meet the following educational requirements to receive privileges in anesthesiology:
Graduation from a medical school accredited by the Liaison Committee on Medical Education, AOA, or a foreign medical school accepted and verified by the Education Commission on Foreign Medical Graduates

Completion of an ACGME- or AOA-approved anesthesiology residency program

Certification by the ABA

Completion with ABA Maintenance of Certification in Anesthesiology Program

Current Physician’s Recognition Award of the AMA, or completion of 100 hours of CME over two years, of which 40 hours are in Category 1 of the ACGME

Compliance with state or institutional requirements for CME

At least 50% of CME hours in the primary specialty of practice

Demonstration of competence in advanced life support

Physicians should hold a current, active, unrestricted medical or osteopathic license and current, unrestricted DEA registration, and should disclose any disciplinary action against any medical or osteopathic license by any federal agency in the last five years.

ASA states that physicians should be members of an organization that conducts peer review and should actively participate in an ongoing process that evaluates clinical performance and patient care results. Physicians should disclose any record of felony or fraud conviction. Additionally, ASA recommends that physicians agree in writing to abide by the ASA’s Guidelines for the Ethical Practice of Anesthesiology. These guidelines elaborate on the ethical responsibilities that anesthesiologists have to themselves, their patients, their medical colleagues, their healthcare facilities, their community, and society.

**ACGME**

ACGME publishes Program Requirements for Graduate Medical Education in Anesthesiology, which states that a physician must complete a minimum of four years of graduate medical education in anesthesiology. Three years of training must be in clinical anesthesia. The first year of education, known as the clinical base year (CBY), should provide 12 months of broad education in medical disciplines related to the field of anesthesiology.

At least six months of the CBY rotations must include experience in caring for inpatients in internal medicine, pediatrics, surgery or any of the surgical specialties, obstetrics and gynecology, neurology, family medicine, or any combination of these areas. Residents should also devote at least one month, but no more than two months, to both critical care and emergency medicine. Up to one month of the CBY may be in anesthesiology. The CBY should allow residents to develop clinical skills and mature clinical judgment, and should give residents responsibility for decision-making and direct patient care under proper supervision. The resident should develop the following clinical skill competencies in the CBY:
Obtain a comprehensive medical history
Perform a comprehensive physical examination
Assess a patient’s medical conditions
Make appropriate use of diagnostic studies and tests
Integrate information to develop a differential diagnosis
Implement a treatment plan

Following the CBY, residents must complete three years of training in basic and advanced anesthesia (CA-1, CA-2, and CA-3). Training should encompass all aspects of perioperative care to include evaluation and management during the preoperative, intraoperative, and postoperative periods. The training must progressively challenge residents’ cognitive and technical skills and should culminate in sufficiently independent responsibility for clinical decision-making and patient care. Residents should receive training in surgical anesthesia, critical care medicine, and pain medicine, as well as training in complex technology and equipment associated with these practices.

During the three years of clinical anesthesia training, residents must complete a minimum of two identifiable one-month rotations in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. Additional subspecialty rotations are encouraged, but the cumulative time in any one subspecialty should not exceed six months.

Experiences in perioperative care must include rotations in critical care medicine, acute perioperative and chronic pain management, preoperative evaluation, and postanesthesia care. These experiences must include:

- At least four months of distinct progressive rotations in critical care medicine
- At least three months in pain medicine that may include:
  - One month in an acute perioperative pain management rotation
  - One month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain problems
  - One month of regional analgesia experience in pain medicine
- One month in a preoperative evaluation clinic
- Half a month in a postanesthesia care unit

All residents must hold current certification as providers for advanced cardiac life support.

Residents must have broad exposure to different types of anesthetic management within the residency program. Residents must obtain the following minimum clinical experiences, in which care is provided for the following:

- 40 patients undergoing vaginal delivery
- 20 patients undergoing cesarean sections
- 100 patients less than 12 years of age undergoing surgery or other procedures requiring anesthetics, of which 20 children must be less than 3 years of age,
including five less than 3 months of age
➤ 20 patients undergoing cardiac surgery, the majority of which must involve the use of cardiopulmonary bypass
➤ 20 patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery
➤ 20 patients undergoing noncardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures
➤ 20 patients undergoing intracerebral procedures, including those undergoing intracerebral endovascular procedures; the majority of these 20 procedures must involve an open cranium
➤ 40 patients undergoing surgical procedures, including cesarean sections, in whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for perioperative analgesia
➤ 20 patients undergoing procedures for complex, life-threatening injuries (e.g., trauma associated with car crashes, falls from high places, penetrating wounds, industrial and farm accidents, assaults, or burns covering more than 20% of body surface area)
➤ 40 patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics
➤ 40 patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or perioperative analgesic management
➤ 20 new patients who are evaluated for management of acute, chronic, or cancer-related pain disorders

Residents should also have experience with patients with acute postoperative pain, patients scheduled for evaluation prior to elective surgical procedures, patients who require specialized techniques for their perioperative care, patients immediately after anesthesia, patients undergoing diagnostic or therapeutic procedures outside of the surgical suites, and critically ill patients.

Residents should have didactic instruction that encompasses clinical anesthesiology and related areas of basic science, as well as pertinent topics from other medical and surgical disciplines. Practice management should be included in the curriculum and should address issues such as operating room management, types of practice, job acquisition, financial planning, contract negotiations, billing arrangements, professional liability, and legislative and regulatory issues. The material covered in the didactic program should demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held teaching conferences. The number and types of such conferences may vary among programs, but there must be evidence of regular faculty participation.
Residents must have appropriate didactic instruction and sufficient clinical experience in managing problems of the geriatric population, as well as the specific needs of the ambulatory surgical patient.

**AOA/AOCA**

The AOA, in conjunction with the AOCA, publishes *Basic Standards for Residency Training in Anesthesiology*. According to this document, residency training in anesthesiology should take place over a four-year period. In the first year (OGME-1), residents should complete 12 one-month rotations or 13 four-week rotations that cover a broad overview of medicine. Eight of the rotations must be divided as follows:

- One rotation in critical care
- Three rotations in inpatient internal medicine relevant to the practice of anesthesiology
- Two rotations in surgery, one of which is general surgery and one of which is vascular, orthopedic, urologic, or ENT
- One rotation in pediatrics (inpatient or ambulatory)
- One rotation in obstetrics and gynecology, if available, or female reproductive medicine

The OGME-1 year must also provide a maximum of four months of anesthesia, to include the following:

- Osteopathic principles and practice
- Airway management
- Basic pharmacology
- Anesthesia machine
- Methods of anesthesia delivery
- Perioperative evaluation and management
- Patient monitoring
- Anesthesia and systemic disease
- Introduction to regional anesthesia

The second and third years of training should emphasize a progression of core anesthesia knowledge and skills, including the following elements:

- Training in complex technology and equipment, such as transesophageal echocardiography, ultrasound-guided anesthesia, extracorporeal membrane oxygenator or cardiopulmonary bypass, and Swan-Ganz placement and parameters
- Advanced airway management, such as fiber-optic-guided intubations and other airway devices
- Neuro-axial anesthesia
- Peripheral nerve blocks
- Concepts of anesthesia and coexisting disease
- Acute pain management
- Chronic pain management
- Pharmacology
➤ Patient monitoring and procedures
➤ Advanced concepts in perioperative care
➤ Age-specific anesthetic considerations
➤ Anesthesia outside the operating room
➤ Single-lung ventilation management
➤ Critical care medicine
➤ Medical-legal considerations in the practice of anesthesia
➤ Economics of practice
➤ Use of musculoskeletal findings in clinical problem solving and establishing indications for osteopathic manipulative therapy
➤ Integrated radiology exposure as clinically relevant
➤ Exposure to core surgical disciplines, including:
  – Neurosurgery
  – Cardiothoracic anesthesia
  – Obstetric analgesia and anesthesia
  – Orthopedic surgery
  – Urology
  – General surgery
  – Ophthalmic
  – ENT
  – Anesthesia for trauma patients
  – Pediatric anesthesia
  – Geriatric anesthesia
  – Outpatient anesthesia
  – Post-anesthesia care unit (PACU)
  – Plastic surgery

The fourth year of residency training should consist of 12 months of advanced training, with the resident managing the most complex anesthesia cases (i.e., one-lung anesthesia, specific nerve block procedures, both therapeutic and diagnostic). Alternately, the resident may elect to complete nine months in one of the subspecialty rotations and three months in comprehensive and complex assignments from the following areas:
➤ Critical care medicine
➤ Acute and chronic pain management
➤ Research-oriented programs
➤ Coma-induced anesthesia
➤ Pediatrics
➤ Obstetrics
➤ Cardiovascular
➤ Pulmonary
➤ Neurosurgery

Residents must demonstrate the ability to rapidly evaluate, initiate, and provide treatment for patients who are critically ill using medical practice. This includes the ability to implement acceptable treatments for acute or chronic disease
entities. Residents should also demonstrate competency in understanding and applying clinical skills specific to the practice of anesthesia, and demonstrate knowledge in the complex treatment options of anesthesiology. During training, residents should develop the skills needed to practice within a systems-based healthcare environment, as well as professional leadership and practice management skills.

Positions of accreditation bodies

CMS

The CMS Conditions of Participation (CoP) define a requirement for anesthesia services in §482.52 stating, “If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.”

§482.52(a) states, “The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by—

1. A qualified anesthesiologist;
2. A doctor of medicine or osteopathy (other than an anesthesiologist);
3. A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
4. A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or
5. An anesthesiologist’s assistant, as defined in §410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.”

Additionally, CMS states in §482.52(b) that “Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and post anesthesia responsibilities.”

Hospitals must provide a preanesthesia evaluation, an intraoperative anesthesia record, and a postanesthesia evaluation for each patient.

CMS notes in §482.52(c)(1) that “A hospital may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State’s Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of
anesthesia services in the State and has concluded that it is in the best interests of the State’s citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.”

The CMS CoPs 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 addresses anesthesia in PC.03.01.01 of its Comprehensive Accreditation Manual for Hospitals. According to The Joint Commission, operative and other invasive procedures must be planned by qualified and credentialed individuals. Additionally, The Joint Commission requires that “All individuals who administer moderate or deep sedation and anesthesia are qualified and have the appropriate credentials to manage patients, regardless of the level of sedation or anesthesia achieved” (PC.03.01.01, EP 2). Appropriate equipment and resuscitation services must also be available for the operative and invasive procedures requiring sedation or anesthesia.

In PC.03.01.01, EP 10, The Joint Commission states, “Anesthesia is administered by an anesthesiologist, an MD or DO (other than an anesthesiologist), DDS, DMD, DPM, a supervised CRNA (unless state exempts from supervision), an anesthesiologist assistant under supervision of the anesthesiologist, or a supervised trainee in an accredited or licensed program. This must be designated in hospital policy and be in conformance with state laws that define the scope of practice for these practitioners.”

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) adheres to the same requirements outlined in CMS CoP §482.52, §482.52(a)(1-5), and §482.52(c)(1-2) with regards to anesthesia services (30.01.01, 30.01.03).

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 establishes 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

In its accreditation standard AS.1 Organization, DNV states, “Anesthesia services are provided in an organized manner and function under the direction of a qualified MD or DO. The service is responsible for all anesthesia administered.” Regarding the administration of anesthesia, AS.2 states, “Anesthesia is administered only by a qualified anesthesiologist or MD/DO (other than an anesthesiologist); a dentist, oral surgeon, or podiatrist qualified to administer anesthesia under state law; a CRNA or anesthesiologist’s assistant under the supervision of the operating practitioner or an anesthesiologist who is immediately available if needed.”

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 anesthesiology. 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 privileges in anesthesiology**

**Basic education**: MD or DO  
**Minimal formal training**: Successful completion of an ACGME- or AOA-accredited residency in anesthesiology, and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in anesthesiology by the ABA or the AOBA  
**Required current experience**: [n]¹ hospital anesthesiology cases, reflective of the scope of privileges requested, within 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 anesthesiology**

Core privileges for anesthesiology include the ability to administer anesthesia, including general, regional, and local, and administration of all levels of sedation to [pediatric], adolescent, and adult patients. Note that ages of patients treated should be specific to the setting. The American Academy of Pediatrics recommended categories as follows: 0 to 1 month, 1 to 6 months, 6 months to 2 years, and older than 2 years, with additional differentiation of pediatric age groups for

¹ Healthcare organizations should define the minimum case/patient volume (the “[n]”) required to maintain clinical competence as recommended by the applicable department chair and the medical executive committee and subject to approval by the governing board.
patients older than 2 years recommended.
Care includes pain relief and maintenance, or restoration, of a stable condition
during and immediately following surgical, obstetrical, and diagnostic procedures.
Anesthesiologists may provide care to patients in the intensive care setting in con-
formance with unit policies. Core privileges also include the ability to assess, stabi-
lize, 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.

➤ Adolescent and adult anesthesiology
  – Performance of history and physical exam
  – Assessment of, consultation for, and preparation of patients for anesthesia
  – Clinical management and teaching of cardiac and pulmonary resuscitation
  – Diagnosis and treatment of acute, chronic, and cancer-related pain
  – Evaluation of respiratory function and application of respiratory therapy
  – Image-guided procedures
  – Management of critically ill patients
  – Monitoring and maintenance of normal physiology during the periopera-
tive period
  – Relief and prevention of pain during and following surgical, obstetric,
therapeutic, and diagnostic procedures using sedation/analgesia, general
anesthesia, and regional anesthesia
  – Supervision and evaluation of performance of personnel, both medical and
paramedical, involved in perioperative care
  – Supervision of CRNAs
  – Treatment of patients for pain management (excluding chronic pain
management)

➤ Adult cardiothoracic anesthesiology
  – Performance of history and physical exam
  – Anesthetic management for patients undergoing minimally invasive cardiac
surgery and for congenital cardiac procedures performed on adult patients
  – Anesthetic management of adult patients for cardiac pacemaker and auto-
matic implantable cardiac defibrillator placement, surgical treatment of
cardiac arrhythmias, cardiac catheterization, and cardiac electrophysiologic
diagnostic/therapeutic procedures
  – Anesthetic management of adult patients undergoing surgery on the ascend-
ing or descending thoracic aorta requiring full cardiopulmonary bypass
(CPB), left heart bypass, and/or deep hypothermic circulatory arrest
  – Anesthetic management of patients undergoing noncardiac thoracic surgery
  – Image-guided procedures
  – Management of intra-aortic balloon counterpulsation
  – Management of nonsurgical cardiothoracic patients
  – Management of patients with left ventricular assist devices
  – Management of adult cardiothoracic surgical patients in a critical care
(ICU) setting
Anesthesiology

Practice area 125

- Transesophageal echocardiography

➤ Obstetric anesthesia
- Performance of history and physical exam
- All types of neuraxial analgesia (including epidural, spinal, combined spinal, and epidural analgesia) and different methods of maintaining analgesia (such as bolus, continuous infusion, and patient-controlled epidural analgesia)
- Anesthetic management of both spontaneous and operative vaginal delivery, retained placenta, cervical dilation, and uterine curettage, as well as postpartum tubal ligation, cervical cerclage, and assisted reproductive endocrinology interventions
- Consultation and management for pregnant patients requiring nonobstetric surgery
- General anesthesia for cesarean delivery
- Image-guided procedures
- Interpretation of antepartum and intrapartum fetal surveillance tests

Special noncore privileges in anesthesiology

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 transesophageal echocardiography.

Reappointment

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

To be eligible to renew privileges in anesthesiology, the applicant must demonstrate current competence and an adequate volume of experience ([n] hospital anesthesia cases) 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 anesthesiology should be required.

For more information

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**American Board of Medical Specialties**
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Telephone: 312-436-2600
Website: www.abms.org

**American Osteopathic Association**
142 Ontario Street
Chicago, IL 60611-2864
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**American Osteopathic Board of Anesthesiology**
2260 East Saginaw Street, Suite B
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DNV Healthcare, Inc.
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Healthcare Facilities Accreditation Program
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