Plastic surgery

Background

According to the American College of Surgeons (ACS), plastic surgery encompasses the repair, reconstruction, or replacement of physical defects of form or function involving the skin, cranio-maxillofacial structures, musculoskeletal system, breast and trunk, extremities, hands, and external genitalia. Plastic surgery also entails the use of innovative techniques such as microvascular surgery, liposuction, and tissue transfer.

The ACS states that special knowledge is necessary to achieve skill in the design and surgery of grafts, flaps, free tissue transfer, and replantation. Further, plastic surgeons also must have competence in managing complex wounds, using implantable materials, and performing tumor surgery.

The field of plastic surgery encompasses several surgical areas: cranio-maxillofacial surgery, microvascular surgery, hand surgery, and cosmetic surgery. Despite being broad, the plastic surgery specialty offers flexibility with practice settings ranging from academic institutions to private practice. A practice can focus on repairing traumatic injuries or on elective surgery, such as breast reconstruction. Conducting academic research in plastic surgery also is an option.

Training standards published by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Plastic Surgery (ABPS) require plastic surgeons to complete either:

➤ Six years of ACGME-accredited plastic surgery education after medical school, 36 months of which is focused on plastic surgery education, including 12 months as chief resident
➤ Three years of focused plastic surgery education, including 12 months as chief resident, after completing one of the following prerequisites:
   – ACGME-approved residency in surgery, otolaryngology, orthopedic surgery, neurological surgery, or urology
   – American Dental Association (ADA)–approved oral and maxillofacial surgery educational program for individuals with DMD/MD or DDS/MD degrees

According to the ABPS, both of these training modules consist of the resident acquiring a basic surgical knowledge base and experience with principles of surgery, as well as plastic surgery principles and practice, including in-depth understanding of specific plastic surgery techniques.
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Plastic surgeons can choose to focus their practice on general plastic surgery, or may receive additional training in two different subspecialties. Often, one to three years of additional training are required for subspecialty training. The American Board of Medical Specialties (ABMS) recognizes the following subspecialties of plastic surgery:

➤ Plastic surgery of the head and neck
➤ Surgery of the hand (See Clinical Privilege White Paper—Practice area 160)

Involved specialties

Plastic and reconstructive surgeons

Positions of specialty boards

ABPS

The ABPS publishes training and certification requirements in its yearly Booklet of Information. The information below is from the booklet effective July 1, 2012, to June 30, 2013. There are two approved residency training models for plastic surgery: the independent model and the integrated model. Both models are divided into two parts:

➤ Prerequisite training, during which residents attain a basic surgical science knowledge base and experience with principles of surgery
➤ Plastic surgery principles and practice, during which residents gain in-depth understanding of specific plastic surgery techniques

In the independent model, residents complete prerequisite training outside the plastic surgery residency, whereas in the integrated model, all training occurs during the residency.

Residents entering plastic surgery training must complete five progressive years of clinical general surgery residency training, sufficient to qualify for certification by the American Board of Surgery (ABS), unless three years of general surgery are completed in the same program as the plastic surgery residency training. The minimum acceptable residency year, for both prerequisite and requisite training, must include at least 48 weeks of full-time clinical training experience per year. Research rotations or years are not included in the required 48 weeks per year.

For the independent model, the following prerequisite training is required:

➤ Minimum of five years of general surgery training, sufficient to qualify for ABS certification
  – If a general surgery residency is not completed, the physician should have clinical experiences appropriate to plastic surgery education, including abdominal surgery, alimentary tract surgery, breast surgery, emergency medicine, pediatric surgery, surgical critical care, surgical oncology, transplantation, trauma management, and vascular surgery.
- Residents should have the following clinical experiences: acute burn management, anesthesia, dermatology, oculoplastic surgery or ophthalmology, oral and maxillofacial surgery, and orthopedic surgery.
- Successful completion of an ADA-approved residency in oral and maxillofacial surgery may also be used as an alternative prerequisite training prior to plastic surgery residency. The residency must include a minimum of two years of training exclusively in clinical general surgery after MD degree attainment.

The ABPS-specified requisite training is required for both the independent and integrated models.

According to the ABPS, residents should gain increasing levels of responsibility over the course of training. Training in plastic surgery must cover the entire spectrum of plastic surgery. It should include requisite 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
➤ Cranio-maxillofacial trauma, including fractures
➤ Aesthetic (cosmetic) surgery of the head and neck, trunk, and extremities
➤ Plastic surgery of the breast
➤ Surgery of the hand/upper extremities
➤ 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

Specialized plastic surgery training should emphasize the relationship of basic science—anatomy, pathology, physiology, biochemistry, and microbiology—to surgical principles fundamental to all branches of surgery and especially to plastic surgery. In addition, the training program must provide in-depth exposure to the care of emergencies, shock, wound healing, blood replacement, fluid and electrolyte balance, pharmacology, anesthetics, and chemotherapy.

Residents can officially begin a plastic surgery training program (requisite training) after completion of any of the prerequisite options. However, the three-year prerequisite pathway will be discontinued July 1, 2015, and full general surgery training will be required for all individuals entering plastic surgery residencies on and after July 1, 2019.

The integrated model requires at least six years of residency training, which should include the basic experience in clinical general surgery, as well as the requisite, specialized plastic surgery training. At least three years must be
Plastic surgery, concentrated in plastic surgery, and the final 12 months must entail senior clinical plastic surgery responsibility. The last three years of training must be completed in the same program.

**AOBS**

The American Osteopathic Board of Surgery (AOBS) offers certification in plastic and reconstructive surgery. The following are candidate training requirements for the independent training program:

- Two years of plastic and reconstructive surgery training after completing one of the following prerequisites:
  - Three years of American Osteopathic Association (AOA)-approved general surgery training
  - An AOA-approved and completed residency in orthopedic surgery
  - An AOA-approved and completed residency in otolaryngology

The following are candidate training requirements for the integrated training program:

- Six years of plastic and reconstructive surgery training, which includes an AOA-approved common surgery OGME-1R year
- Thirty-six months concentrated in plastic and reconstructive surgery education

Candidates for certification must successfully complete written, oral, and clinical certifying examinations.

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

**ACS**

The ACS states that competency in plastic surgery implies a special combination of basic knowledge, surgical judgment, technical expertise, ethics, and interpersonal skills in order to achieve satisfactory patient relationships and problem resolution.

Training in plastic surgery involves the resection, repair, replacement, and reconstruction of defects of form and function of the skin and its underlying anatomic systems, including the craniofacial structures, the oropharynx, the trunk, the extremities, the breast, and the perineum. It also includes aesthetic (cosmetic) surgery of structures with undesirable form. Special knowledge and skill in the following is required:

- Design and transfer of flaps
- Transplantation of tissues
- Replantation of structures
- Skill in excisional surgery
- Management of complex wounds
- The use of alloplastic materials
According to the ACS, residency training should educate and train physicians broadly in plastic and reconstructive surgery and should foster the development of high moral and ethical character to help form capable, independent surgeons.

A variety of educational tracks are available. The ACS states that all prerequisite residency training must be taken within programs accredited by one of the following organizations: the ACGME, the Royal College of Physicians and Surgeons of Canada, or the ADA. The curriculum for residency training in plastic surgery is two years, according to the ACS.

**ASPS**

In March 2012, the American Society of Plastic Surgeons (ASPS) published a booklet, *Plastic Surgeons: A Delineation of Qualifications for Clinical Privileges*, to facilitate understanding of plastic surgery training requirements. According to the ASPS, an important qualifier for physicians requesting plastic surgery privileges is that they are certified by the ABPS, a member board of the ABMS.

The ASPS lists the following specific procedures as ones that are commonly performed by plastic surgeons:

- **Skin neoplasms, diseases, and trauma**
  - Benign and malignant lesions of the skin and soft tissue
  - Reconstructive grafts and flaps
  - Scar revisions
  - Laser therapy for vascular lesions
- **Breast surgery**
  - Breast reconstruction
  - Breast reduction
  - Breast biopsy
  - Congenital anomalies
  - Mastectomy (subcutaneous and simple)
  - Breast augmentation
- **Treatment of facial diseases and injuries including maxillofacial structures**
  - Facial fractures including the mandible
  - Acquired or congenital deformities of the nose, ear, jaw, eyelid, lips, and palate
  - Craniofacial surgery
  - Skull base surgery
  - Facial deformity and wound treatment
  - Tumors of the head and neck
- **Surgery of the hand and extremities**
  - Soft-tissue wounds and congenital deformities
  - Abnormalities of the hand and upper extremities
  - Extremity fractures and congenital deformities
  - Abnormalities of the bones of the hand, wrist, and distal forearm
  - Carpal tunnel syndrome (endoscopic and open)
  - Dupuytren’s contracture
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− Surgery for rheumatoid arthritis

➤ Reconstructive microsurgery
− Microvascular flaps and grafts
− Replantation and revascularization of the upper and lower extremities and digits
− Reconstruction of peripheral nerve injuries

➤ Reconstruction of congenital and acquired defects of the trunk and genitalia
− Vaginal reconstruction
− Repair of penis deformities
− Gender reassignment
− Chest and abdominal wall reconstruction

➤ Complex wound healing and burn treatment
− Initial burn management
− Acute and reconstructive burn treatment

➤ Cosmetic surgery
− Body contouring
− Facial contouring
− Breast augmentation
− Breast lift (mastopexy)
− Cosmetic rhytidectomy
− Cosmetic rhinoplasty
− Cosmetic blepharoplasty
− Subcutaneous injections/Botox®/filler material
− Skin peeling and dermabrasion
− Vein injection sclerotherapy
− Liposuction
− Endoscopic cosmetic surgery
− Laser therapy for vascular and cutaneous lesions

➤ Skin surgery
− Resurfacing
− Chemical peel
− Laser skin resurfacing
− Mechanical dermabrasion

ASPS also stresses CME as an important component of clinical competence and requires its members to obtain 150 hours of CME within a three-year period.

**ACGME**

In its *Program Requirements for Graduate Medical Education in Plastic Surgery* (effective since July 1, 2009), the ACGME states that residency training programs in plastic surgery should integrate ACGME competencies into the curriculum.

With regard to patient care, residents must provide compassionate, appropriate, and effective patient care while treating problems and promoting health. They also should have clinical experience in the following areas:
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➤ Congenital head and neck defects (e.g., cleft lips and palate, craniofacial surgery)
➤ Head, neck, and oropharynx neoplasms
➤ Cranio-maxillofacial trauma (e.g., fractures)
➤ Head, neck, trunk, and extremity cosmetic surgery
➤ Breast plastic surgery
➤ Hand/upper extremity surgery
➤ Lower extremity plastic surgery
➤ Trunk and genitalia plastic surgery
➤ Burn reconstruction
➤ Microsurgical techniques relevant to plastic surgery
➤ Tissue transfer, flaps, and grafts for reconstructive surgery
➤ Surgery to remove benign and malignant skin and soft tissue lesions

Residents are also strongly encouraged to receive clinical training in the following areas prior to focusing on plastic surgery:
➤ Acute burn management
➤ Anesthesia
➤ Oral and maxillofacial surgery
➤ Dermatology
➤ Oculoplastic surgery or ophthalmology
➤ Orthopedic surgery

Residents must have an organized, supervised clinical experience with an inpatient service that includes the following:
➤ An opportunity to see patients, establish provisional diagnoses, and initiate preliminary plans prior to treatment
➤ An opportunity for follow-up care so that results of surgical treatment can be evaluated by the responsible residents
➤ Faculty supervision

Residents participating in patient care in private practice should work with an appropriate degree of responsibility and adequate supervision.

With respect to medical knowledge, residents should understand and apply to patient care the evolving biomedical, clinical, epidemiological, and social-behavioral sciences. They must:
➤ Have conferences that include anatomy, physiology, pathology, genetics, embryology, microbiology, radiation oncology, pharmacology, practice management, ethics, and medico-legal sessions.
➤ Participate and present educational material at conferences.
➤ Be exposed to surgical design, surgical diagnosis, embryology, surgical and artistic anatomy, surgical physiology and pharmacology, wound healing, surgical pathology and microbiology, adjunctive oncological therapy,
biomechanics, rehabilitation, and surgical instrumentation are fundamental to the specialty. Residents should use sound judgment and have the technical capabilities to achieve satisfactory surgical results.

With regard to practice-based learning and improvement, plastic surgery residents should be able to investigate and evaluate their care of patients, appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and lifelong learning. They should develop skills that allow them to achieve the following goals:

➤ Identify strengths and limitations in one’s knowledge and experience
➤ Set goals for learning and improvement
➤ Identify and perform appropriate learning activities
➤ Systematically analyze practice using quality improvement methods and implement changes warranted
➤ Incorporate evaluation feedback into practice
➤ Identify, evaluate, and assimilate evidence from studies related to patients’ health problems
➤ Employ information technology in learning
➤ Educate patients, caregivers, students, and other healthcare professionals

Plastic surgery residents must exhibit interpersonal and communication skills that assist in the communication of information and collaboration with healthcare professionals, patients, and their caregivers. In doing so, residents should:

➤ Communicate with patients, caregivers, and members of the public with a variety of socioeconomic and cultural backgrounds
➤ Communicate effectively with physicians, other health professionals, and health-related agencies
➤ Collaborate as a member or leader of a healthcare team or other professional group
➤ Act in a consultative role to other healthcare professionals
➤ Maintain comprehensive, legible, and timely medical records

Plastic surgery residents should commit to accepting professional responsibilities and adhere to ethical principles. In doing so, residents should demonstrate:

➤ Compassion, integrity, and respect for others
➤ Responsiveness to patient needs that supersedes self-interest
➤ Respect for patient privacy and autonomy
➤ Accountability to patients, society, and the profession
➤ Sensitivity and responsiveness to a diverse patient population, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation

Plastic surgery residents should be aware of and responsive to the system of healthcare as a whole, and should possess the ability to call effectively on other resources in the system to provide optimal care. As such, residents should:
Be able to work in a range of healthcare settings
- Coordinate patient care
- Consider costs and risk-benefit profiles in patient and/or population-based care
- Advocate for quality patient care and optimal patient care systems
- Work in interdisciplinary teams to optimize patient safety and care quality
- Identify system errors and implement solutions
- Work in teams and communicate necessary information to ensure safety and proper patient care, including when patients’ care transitions between settings
- Recognize and function effectively in high-quality care systems

AOA and ACOS

According to the AOA’s and American College of Osteopathic Surgeons’ (ACOS) Specific Basic Standards for Osteopathic Fellowship Training in Surgery and the Surgical Subspecialties (revised July 2011), core competencies in plastic surgery include:

- Osteopathic philosophy and osteopathic manipulative medicine: Employ osteopathic principles when diagnosing and managing patient clinical presentations
- Medical knowledge: Possess a deep understanding of the complex differential diagnoses and treatment options in internal medicine and the ability to integrate the applicable sciences with clinical experiences
- Patient care: Efficiently evaluate, initiate, and provide appropriate treatment for inpatients and outpatients with acute and chronic conditions, and promote health maintenance and disease prevention
- Interpersonal and communication skills: Communicate clearly while being sensitive and respectful of other healthcare professionals, caregivers, and patients, including those with communication barriers such as sensory impairments, dementia, and language differences
- Professionalism: Conduct oneself ethically and with integrity
- Practice-based learning and improvement: Commit to lifelong learning and scholarly pursuit in internal medicine for the betterment of patient care
- Systems-based practice: Exhibit skills that allow for the effective leadership of healthcare teams in the delivery of quality patient care using all available resources

Residents should have experience in comprehensive histories and physicals, including structural examinations, pelvic exams, rectal exams, breast exams, male genital exams, central venous line placement, arterial puncture for arterial blood gases, osteopathic manipulative treatment and endotracheal intubation (to include, at minimum, indications, contraindications, complications, limitations, and evidence of competent performance), arthrocentesis, peripheral blood smears, exercise stress tests, ambulatory ECG monitors, lumbar puncture, spirometry, sputum gram stain, urine microscopy, vaginal wet mounts, and thoracentesis (to include, at minimum, indications, contraindications, complications, limitations, and interpretation); as well as the interpretation of electrocardiograms, chest x-rays, and flat and upright abdominal films
According to the ACOS and AOA, residents training in plastic and reconstructive surgery must spend no more than 25% of the three-year program in non-affiliated training sites, and must train in the following basic sciences:

➤ Musculoskeletal biomechanics
➤ Surgical physiology and anatomy
➤ Fluids and electrolytes
➤ Shock and resuscitation
➤ Burn therapy
➤ Wound healing
➤ Pathology
➤ Microbiology
➤ Immunology
➤ Hematology
➤ Nutrition
➤ Laser safety
➤ Micro lab
➤ Facial plating
➤ Advanced rhinoplasty

Residents should also have experience in the preoperative, intraoperative, and postoperative care of the following patient categories:

➤ Congenital deformities
➤ Malignant and benign tumors of the head, neck, skin, and soft tissue
➤ Trauma and consequent deformities of the face, trunk, and lower extremity
➤ Aesthetic procedures
➤ Breast surgery
➤ Burns
➤ Microsurgery

Residents should take the following subspecialty electives, if desired: anesthesiology, craniofacial surgery, urological surgery, laser techniques, orthopedic surgery, pediatric plastic surgery, surgical oncology, oral and maxillofacial surgery, oculoplastic surgery, and gender reassignment surgery.

Residents should participate in at least 900 major plastic surgery procedures as a surgeon or assistant, and are required to serve as chief resident in the final 12 months of training.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for plastic surgeons. 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 plastic surgeons. 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 plastic surgeons. 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 plastic surgeons. 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 plastic surgery. 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 as a plastic surgeon**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME- or AOA-accredited residency in plastic surgery, and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in plastic surgery by the ABPS or AOBS in plastic and reconstructive surgery

**Required current experience:** Performance of at least 100 plastic surgery procedures, reflective of scope of privileges requested, in the last 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 for plastic surgery**

Core privileges for plastic surgery include the ability to admit, evaluate, diagnose, and provide consultation to patients of all ages and surgically repair, reconstruct, or replace physical defects of form or function involving the skin, musculoskeletal system, cranio-maxillofacial structures, hand, extremities, breast, trunk, and external genitalia, or perform cosmetic enhancement of these areas of the body. Physicians may provide care to patients in the intensive care setting in conformance with unit policies. They may also 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:

- **Performance of history and physical exam**
- **Treatment of skin neoplasms, diseases, and trauma**
  - Removal of benign and malignant lesions of the skin and soft tissue
  - Reconstruction by tissue transfer, including grafts and flaps
  - Reconstruction of soft tissue disfigurement/scar revisions
  - Surgery on neoplasms of the head, neck, and oropharynx
- **Breast surgery**
  - Breast reconstruction
  - Breast reduction
  - Breast biopsy
  - Congenital anomalies
  - Mastectomy (subcutaneous and simple)
- **Treatment of facial diseases and injuries including maxillofacial structures**
  - Facial fractures including of the mandible
  - Deformities of the nose, ear, jaw, eyelid, and cleft lip and palate
  - Craniofacial surgery
  - Skull base surgery
  - Facial deformity and wound treatment
  - Tumors of the head and neck
- **Surgery of the hand and extremities**
  - Hand wounds
- **Tendon injuries**
  - Hand/wrist fractures
  - Carpal tunnel syndrome (endoscopic and open)
  - Dupuytren’s contracture
  - Surgery for rheumatoid arthritis
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- Congenital anomalies
- Tumors of the bones and soft tissues

➤ Reconstructive microsurgery
- Microvascular flaps and grafts/free tissue transfer
- Replantation and revascularization of the upper and lower extremities and digits
- Reconstruction of peripheral nerve injuries

➤ Reconstruction of congenital and acquired defects of the trunk and genitalia
- Vaginal reconstruction
- Repair of penis deformities
- Gender reassignment
- Chest and abdominal wall reconstruction

➤ Complex wound healing and burn treatment
- Initial burn management
- Acute and reconstructive burn treatment

➤ Cosmetic surgery
- Contouring (body, facial)
- Breast augmentation
- Breast lift (mastopexy)
- Cosmetic rhytidectomy, rhinoplasty, and blepharoplasty
- Subcutaneous injections
- Skin peeling and dermabrasion
- Vein injection sclerotherapy
- Liposuction (including laser, ultrasonic assisted, and power assisted)
- Endoscopic cosmetic surgery
- Laser therapy for vascular and cutaneous lesions

**Core privileges for refer and follow**

Core privileges for referring and following patients include the ability to perform outpatient preadmission and history and physical exam, order noninvasive outpatient diagnostic tests and services, visit patients in the hospital, review medical records, consult with the attending physician, and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon.

In addition, there are certain noncore privileges that may be requested:

➤ Use of laser
➤ Administration of sedation and analgesia

**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 plastic surgery, the applicant must have current demonstrated competence and an adequate volume of experience ([n]^2 plastic and reconstructive
surgery 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 plastic surgery should be required.

For more information:

**Accreditation Council for Graduate Medical Education**
515 North State Street, Suite 2000
Chicago, IL 60654
Telephone: 312-755-5000
Fax: 312-755-7498
Website: [www.acgme.org](http://www.acgme.org)

**American Board of Plastic Surgery**
Seven Penn Center
1635 Market Street, Suite 400
Philadelphia, PA 19103
Telephone: 215-587-9322
Fax: 215-587-9622
Website: [www.abplsurg.org](http://www.abplsurg.org)

**American College of Surgeons**
633 N. Saint Clair Street
Chicago, IL 60611-3211
Telephone: 312-202-5000
Fax: 800-621-4111
Website: [www.facs.org](http://www.facs.org)

**American Osteopathic Association**
142 East Ontario Street
Chicago, IL 60611
Telephone: 800-621-1773
Fax: 312-202-8200
Website: [www.osteopathic.org](http://www.osteopathic.org)

**American Osteopathic Board of Surgery**
4764 Fishburg Road, Suite F
Huber Heights, OH 45424
Telephone: 937-235-9786
Fax: 937-235-9788
Website: [www.aobs.org](http://www.aobs.org)
American Society of Plastic Surgeons
444 East Algonquin Road
Arlington Heights, IL 60005
Telephone: 847-228-9900
Fax: 847-228-9131
Website: www.plasticsurgery.org

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: www.cms.hhs.gov

DNV Healthcare, Inc.
400 Techne Center Drive, Suite 350
Milford, OH 4515
Website: www.dnvaccreditation.com

Healthcare Facilities Accreditation Program
142 East Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: www.hfap.org

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Fax: 630-792-5005
Website: www.jointcommission.org

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