Intra-abdominal laparoscopic surgery

Background

Promising minimal post-operative pain, shorter lengths of stay and recovery, and less scarring, laparoscopic-assisted surgeries are a significant advance for the treatment of gallbladder disease and other conditions that were once only treated by traditional open surgery. The surgery, performed by inserting surgical instruments and fiber-optic viewing devices through a series of small abdominal incisions, is performed while viewing the internal operative field on a video monitor.

Currently, there are two schools of thought on the initial privileging of laparoscopic procedures, such as cholecystectomy, appendectomy, hernia repair, and the surgical treatment of intra-abdominal adhesions. The first is considered the conservative view of privileging in which a surgeon is privileged separately for each new procedure. The other, deemed a more progressive view, says that at some point a physician becomes a competent laparoscopic surgeon and is able to go on to other procedures without numerous, separate privileging encounters.

Involved specialties

The following are the specialties who have shown an interest in intra-abdominal laparoscopic procedures: urologists, gastroenterologists, and general surgeons.

Positions of societies or academies

The following is a summary of the position of the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), for the procedure of laparoscopic cholecystectomies.

- Formal fellowship or residency training in general surgery.
- For those without residency training or fellowship that included laparoscopic surgery (or without documented prior experience in laparoscopic surgery), the minimum requirements for training should be:
  - Credentialing in diagnostic laparoscopy.
  - Training in laparoscopic general surgery by a surgeon experienced in laparoscopic surgery or completion of a university sponsored or academic society recognized didactic course with clinical experience and hands-on laboratory practice.
  - Observation of laparoscopic surgical procedures performed by a surgeon experienced in the perfor-
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Performance of such procedures.
- Confirmation, in writing, of the training, experience, and actual observed level of competency by the applicant’s laparoscopic training director.

- Proctoring of applicants by a qualified, unbiased surgeon experienced in general and laparoscopic surgery. Criteria of competency for each procedure should be established in advance and a satisfactory mechanism for appeal must be established for individuals whose privileges are denied or granted in a temporary or provisional manner.

- Each surgeon should be monitored through the existing quality assurance mechanisms. This should include monitoring utilization, diagnostic and therapeutic benefits to the patients, complications and tissue review in accordance with previously developed criteria.

- Continuing medical education related to laparoscopic surgery should be required as part of the periodic renewal of privileges.

ACS The American College of Surgeons recommends the granting of clinical privileges based upon evaluation of education, training, experience, and demonstrated current competence.

Positions of other interested parties

In June 1992 the State of New York Department of Health provided hospitals with guidance on how to credential surgeons who perform laparoscopic cholecystectomies. Somewhat more specific than SAGES guidelines, the NYDH suggests the following for surgeons who have not learned laparoscopic cholecystectomy as part of an approved residency program.

- The surgeon must be Board Certified (or admissible for certification by the American Board of Surgery) and credentialed to perform the basic open procedure.

- He or she must successfully complete a laparoscopic practicum that meets the accreditation standards of the America College of Continuing Medical Education. The curriculum must include:

  - Work with laparoscopic equipment.
  - Training in the indications and contraindications of laparoscopic cholecystectomy as well as management of complications and aftercare.
  - Presentations of the theory behind the performance
of the procedure that includes a review of videotapes, the proper performance of the procedure, and the potential complications.

- A laboratory that provides the participant hands-on experience with the use of the equipment on inanimate objects and hands-on experience with animal models. Each student should perform at least one laparoscopic cholecystectomy as the camera operator, the assistant, and the responsible surgeon.

- An objective test of skills.

- Certification of completion.

- The applicant must participate as the assistant surgeon in at least five to 10 procedures to satisfactorily demonstrate knowledge of the risks as well as proficiency with the instruments.

- Following an assessment as an assistant, the governing board can approve privileges to a surgeon to perform under the direct supervision of a surgeon fully credentialed to do the specific laparoscopic procedure. A minimum of between 10 to 15 procedures is recommended.

Monitoring should include a concurrent review of 100 percent of laparoscopic procedures. Additionally, a videotape of all operations should be done.

Provisional status (the in-person supervision by a proctor) should be re-imposed after a serious technical error involving injuries to major blood vessels, viscera, or the portal triad. This status holds until a sufficient number of cases result in no complications.

Performance of this procedure using laser requires a separate credentialing process with additional criteria related to the proper use of laser equipment.

**Position of subject matter experts**

Charles G. Mixter, III, MD, a general surgeon with Exeter (New Hampshire) Surgical Associates, suggests that instead of a separate privileging process for each new procedure requested by surgeons, an initial and advanced category be put in place. Initial privileging should generally follow SAGES guidelines and be limited to three basic procedures, cholecystectomies, appendectomies, and hernia repair. Further, monitoring should not only include how surgeons perform during
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these first few cases, but also how they choose the cases they work on.

Advanced privileges will cover those procedures “added on” after initial privileges have been granted. For those procedures new to a physician, but not new to the facility, the following guidelines apply:

• The physician must demonstrate appropriate knowledge concerning the risks, benefits, appropriateness, and required techniques for the proposed surgery.

• The clinical department will designate those procedures that do not require the presence of a surgeon experienced in the procedure or an outside proctor experienced in the procedure.

• Five consecutive cases will be reviewed either retrospectively, through video documentation, or by a proctor familiar with the procedure.

• Documented informed consent should include the physician’s experience with the procedure.

For procedures new to the facility and the physician, the following apply:

• The physician must demonstrate appropriate knowledge concerning the risks, benefits, appropriateness, and required techniques for the proposed surgery.

• The physician must provide the OR with a written summary sheet (to be approved by the chief of surgical services) in advance of surgery outlining the operative procedure and special equipment needed.

• The physician should provide the OR with education aids describing the procedure.

• Documented informed consent should include the physician’s experience with the procedure.

• The surgeon should be assisted by either an outside proctor experienced in the procedure or another staff physician experienced in general laparoscopic surgery.

• Five consecutive cases will be reviewed either retrospectively, through video documentation, or by a proctor familiar with the procedure.

• A log of new procedures (detailed notes of how the procedure was performed, decisions made during and after sur-


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gery, and the surgeon’s reasoning) should be maintained so that the cases can be reviewed along with the medical record.

CRC draft criteria

The following draft criteria are intended to serve as a starting point for the development of your institution’s policy regarding this procedure.

Initial privileges

Basic education: MD or DO

Minimal formal training: Completion of an approved residency/fellowship program.

Additional training requirement: If not taught in residency, completion of a one and one-half day continuing medical education course in laparoscopic procedures, including actual practice as assistant, camera operator, and primary surgeon during at least one procedure on a live (non-rodent) animal such as a pig weighing at least 50 pounds.

Required direct and indirect experience: Performance of at least 150 conventional open procedures during the past two years.

Advanced privileges

Meets all of the above and has also completed an advanced course similar to that described above concerning intra-abdominal laparoscopic surgery. Performed at least 30 laparoscopic procedures during the past 12 months.

The information contained in this document has been designed and intended for use by hospitals and their credentials committees in developing their own local approaches and policies for various credentialing issues. These materials, opinions, and draft criteria should not be adopted for use without careful consideration, discussion, and additional research by physicians in local settings. The Credentialing Resource Center does not provide legal or clinical advice; for such advice, the counsel of competent individuals in these fields must be obtained.