SURGERY CLINICAL SERVICE
RULES AND REGULATIONS

~~2015~~2018

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RULES AND REGULATIONS
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I. SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

1. The Surgery Service consists of the following surgical specialties: elective general surgery; emergency general surgery; trauma, plastic surgery, vascular surgery, thoracic surgery, colorectal surgery, minimally invasive surgery and surgical critical care.

2. The Trauma and General Surgery Service will care for all patients admitted to the hospital for acute traumatic problems as well as all patients admitted through the Emergency Medicine Service for acute or emergent non-traumatic surgical problems.

3. The Trauma and General Surgery Service will also consist of all patients who present through the Surgical Clinic with non-urgent surgical problems including those admitted for any of the surgical subspecialties listed above (excluding plastic surgery).

4. The Plastic Surgery Service will care for all patients who need reconstructive surgery, both emergently and electively.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in ~~SFGH~~ ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION AND STAFFING OF THE SURGERY CLINICAL SERVICE

1. The Organization of Surgery Clinical Services Officers is as follows: (Note: See also attached Organizational Chart)*

Chief of Service
~~Vice Chief of Service~~
Chief of Plastic Surgery
Trauma Medical Director
Associate Trauma Medical Director
Surgical Director of the Surgical Intensive Care Unit
Chief of Vascular Surgery
Chief of Thoracic Surgery
Director of Global Surgery
Medical Director of the Soft Tissue Infection Clinic (ISIS)
Director of Surgery Clinic

A. Chief of Service
1) Appointment and Review

Appointment and review of the Chief of Service will occur by the process specified in the Medical Staff Bylaws.

2) Responsibilities
The Chief of Service is responsible for the overall direction of the clinical, teaching and research activities for the Surgery Service including:
(a) Review and recommendation of all new appointments, request for privileges and reappointments.
(b) Appointment of the other officers of the Surgery Service and service on committees.
(c) Financial affairs of the Surgery Service.
(d) Attendance at the Medical Executive Committee, the Dean's Meetings and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.
(e) Disciplinary actions as necessary, as set forth in these rules and regulations in the Bylaws and Rules and Regulations of the Medical Staff.

2. Attending Physician Clinical Responsibilities

A. Overall direction of clinical care is the responsibility of the attending staff of the Surgery Service. In order to discharge that responsibility, close supervision of house-staff and Nurse Practitioners and active participation in the care of each patient on the in-patient service or those seen in the outpatient setting is required.

B. Specific Duties

1) Trauma /General Surgery Service Attending:
Core surgery faculty members are assigned each week to be the attending of record for the service. The service attending makes rounds with the resident team, ~~dictates~~ types daily progress notes in the medical record, responds to major trauma activations in the emergency department, and sees all emergent and non-emergency consults from other services as needed. The Service Attending also oversees all operations performed on consult and service patients (emergent and non-emergent) during the daytime weekday shift. The service attending will be immediately available during their daytime shift unless specific arrangements are made for a back-up surgeon to cover. Any purely elective surgery will not be scheduled by the Service attending
unless specific cross coverage arrangements are made. Clinic responsibilities for the service attending are minimized.

2) In addition to the Trauma/General Surgery Weekly Service Attending, there is an on-call attending for

trauma/emergency surgery that is immediately available to cover the night call (generally 6 PM to 7 AM). This on-call surgeon responds to major trauma activations during his/her shift and conducts or supervises all trauma and emergency general surgery operations during that time. A back-up trauma/general surgeon is also assigned for each shift (day and night) and is promptly available should the on-call surgeon request assistance.

3) ~~All~~ All attending surgeons that are assigned clinic time ~~and~~ are expected to be present for the evaluation of new and follow-up patients scheduled into their elective clinic. Patients in need of surgery will be evaluated by the attending surgeon and consent obtained by the surgeon prior to formal scheduling in the operating room. The surgeon of record will perform or directly supervise the conduct of all elective surgical procedures in the operating room.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ~~SFGH~~ ZSFG through the Surgery Clinical Service will be in accordance with ZS~~F~~GH Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ~~SFGH~~ ZSFG through the Surgery Clinical Service will be in accordance with ~~SFGH~~ ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations. Reappointment to the staff is dependent on continuing demonstration of competence.

C. ONGOING PROFESSIONAL PERFORMANCE EVALUATION (OPPE)

The quality assurance information specific to Surgery Service Practitioners will be maintained by the Chief of Surgery and/or his/her designee and will be used to monitor and report on ongoing professional performance evaluations (Surgery OPPE, Appendix F) and in the data summary sheets provided by the Service Chief at the time of reappointment or re-credentialing.

The process for Staff Status Change for members of the Surgery Services will be in accordance with ZSFG~~H~~ Bylaws, Rules and Regulations, and accompanying manuals.

D. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals through the Surgery Clinical Service will be in accordance with ZSFG~~H~~ Bylaws, Rules and Regulations, as well as with these Clinical Service Rules and Regulations (see Attachment A).

E. STAFF CATEGORIES

Surgery Clinical Service staff fall into the same staff categories that are described in Article III – *Categories of the Medical Staff* of the ZSFG~~H~~ Bylaws, Rules and Regulations, as well as with these Clinical Service Rules and Regulations.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Surgery Clinical Service privileges are developed in accordance with ~~SFGH~~ ZSFG Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations as well as these Clinical Service Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Surgery.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Surgery Clinical Service Privilege Request Form shall be reviewed annually at the time of reappointment to the medical staff

C. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

The Surgery Clinical Service privileges shall be authorized in accordance with the ZSFG~~H~~ Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations as well as these Clinical Service Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Surgery.

Privileges to practice on the Surgery Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice. The specifics of the process and the privileges which will be assigned are described in detail in the **DELINEATION OF PRIVILEGES, SURGERY SERVICE, ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL, ATTACHMENT A.**

Privileges are delineated by consensus of the active medical staff members of the Surgery Service, and are approved by the Chief of Surgery, subject to the approval of the Credentials Committee of the medical staff.

Individuals' privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, at the time as judged necessary by the Chief of Service.
Note: Completion of the medical records including dictation of operative notes within two weeks of the date of operation is a medical staff requirement and individuals who are consistently delinquent may have their privileges suspended.
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The process for Modification/Change to Privileges for members of the Surgery Services will be in accordance with ZSFG~~H~~ Bylaws, Rules and Regulations and accompanying manuals.

Temporary Privileges shall be authorized in accordance with the ZSFG~~H~~ Medical Staff Bylaws, Article V: Clinical Privileges.

IV. PROCTORING AND MONITORING REQUIREMENTS

A. REQUIREMENTS

Proctoring requirements for the Surgery Clinical Service shall be the responsibility of the Chief of the Service.
All requirements and details of proctoring will be delineated in the document

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Surgery Clinical Service shall be in accordance with ZSFG~~H~~ Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Surgery Clinical Service shall be in accordance with ZSFG~~H~~ Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

V. EDUCATION OF MEDICAL STAFF

The Surgery Clinical Services offers weekly educational activities/teaching conferences as follows:

~~SFGH~~ ZSFG Trauma Service Morning Report	Monday-Friday 0630-0730
UCSF Surgery Grand Rounds	Wednesday 0700-0900
ZSFG~~H~~ Surgery Mortality and Morbidity Conference	Every 1st and 3rd Wednesday 1700-1800*
Trauma Multidisciplinary Peer Review (faculty only)*	Monthly - every 4th Wednesday 3-5pm
ZSFG~~H~~ Surgical Case Conferences/ Grand Rounds	Every 2nd and 4th Wednesday 1700-1800*
GI Radiology Conference	Tuesday 1600-1700
Trauma Video Resuscitation Conference	2nd Tuesday 1700-1600
Tumor Board	Thursday 0800-090

Note: Attendance at 50% of ZSFG~~H~~ Surgery Grand Rounds /Case Conference is an expectation for all full-time surgery faculty. Persistent non-compliance may be reported to the medical staff office as part of OPPE.
*>50% attendance at TMPR is a privileging requirement for core trauma panel members

VI. SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that the house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience.

1. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF (Refer to CHN Website for Housestaff Competencies link.)

A. The Trauma and General Surgery Service and the Plastic Surgery Services will be overseen by a Chief Resident in each respective discipline. The Chief Resident in collaboration with senior residents will supervise the junior house staff in all aspects of patient care including the admission history and physical exams, ordering of laboratory and radiologic investigations, house staff rounds on all hospitalized patients, and house staff patient evaluation in the outpatient clinics. All residents are under the supervision of the attending surgeon assigned to the Trauma and General Surgery Service or Plastic Surgery Service, or to the attending surgeons working in the outpatient surgical clinic area. In addition, all residents are directly supervised for all critical portions of the procedure by the attending surgeons in the operating room except for minor procedures such as incision and drainage of abscesses.

B. All surgical residents are assigned specific duties appropriate to their level of training and expertise. These duties are outlined in detail in

Attachment C.4. The surgical curriculum for house staff at the University of California, San Francisco is designed to ensure that the basic fund of knowledge and technical skill for the performance of these duties are taught to the residents under the direct supervision of the faculty. Specific house staff competencies are detailed in Appendix B.

2. RESIDENT EVALUATION PROCESS

The surgical attending staff meet regularly to perform ~~a group~~individual evaluation of the residents and interns assigned to the surgical service at ZSFG~~H~~. This evaluation includes all the components considered essential for progression to the next level training, including professionalism, technical abilities, communication skills, and practice-based learning. These evaluations are provided on-line and made available to the UCSF Surgical Residency Director (or Director from a surgical or medical sub-specialty as appropriate) as well as to the residents themselves for their own self-evaluation. Each resident is given an exit interview by a surgery attending prior to leaving the rotation.

A. Mortality and Morbidity Conference includes discussion of all deaths and important complications with an emphasis on identification of opportunities for changes to systems of care or clinical practice that will improve care.

3. ABILITY TO WRITE PATIENT CARE ORDERS

House staff members may write patient care orders, except as specified by ZSFG~~H~~ policy (for example: DNR or Chemotherapy Agents). The supervising attending surgeon has ultimate responsibility for orders written by the surgical house staff on the patients under their supervision.

VII. SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

Non-emergent, non-urgent surgical consultations are requested through ~~eReferral~~the EHR, by submitting a consultation request form, or by telephone request tendered through a member of the surgical faculty, Fellow, or senior resident. Emergency consultations are requested through contact of the on-call attending, service attending, or on-call senior resident. Emergency consultations are staffed by the either the service or on-call attending surgeon. A record of such consultations will be provided by either the senior resident staff or directly by the attending.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations and accompanying manuals govern all disciplinary action involving members of the ZSFG~~H~~ Surgery Clinical Service.

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

The Chief of Service, or designee, will be responsible for ensuring solutions to surgical performance improvement, and patient safety. As necessary, assistance will be invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization (eg: Executive Committee; OR Committee, Risk Management etc) to:

1. Ensure appropriate care and safety of all patients receiving care in the department. It is understood that this care is provided chiefly in the emergency room, the operating room, the ICU, the surgical wards, and the surgical clinics~~, and the Radiology Department.~~

2. Maximize the safety of patients receiving surgical care.

3. Minimize morbidity and mortality of surgical patients and to avoid unnecessary days of inpatient care.

4. Improve efficiency in delivery of service.

B. RESPONSIBILITY

1. The Chief of Surgery has overall responsibility for the conduct of the Surgical Performance, Improvement and Patient Safety (PIPS) program. The Chief of Surgery may delegate portions of this responsibility to the Trauma Medical Director, ~~the Vice Chief of Surgery~~, or the Director of the ISIS Outpatient Clinic.

C. REPORTING

Performance improvement/patient safety and utilization management activity records will be maintained by the clinical service. Minutes will be sent to the Medical Staff Services Department.

D. CLINICAL INDICATORS

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

F. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

G. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

H. MEDICAL RECORDS

The members of the Surgery Service are committed to the maintenance of complete, accurate and timely medical records. These requirements are set forth in the ZSFG~~H~~ Bylaws and Rules and Regulations which define the minimum standards for Medical Record completion.

1. Operative Records
   Dictated operative reports are required for all major and minor operative procedures performed in the operating suite, whether inpatient or outpatient. Operations or procedures performed in the surgical or ISIS clinics will generally be capable of being performed under local anesthesia and minor in extent. A dictated operative note will not be required for these procedures, but they must be documented in the medical record ~~chart~~ by an operative procedure note.

   Dictated operative reports should, contain the following elements (minimum):
   a. Pre-operative diagnosis
   b. Post-operative diagnosis
   c. Operative procedure(s) performed
   d. Surgeon(s)
   e. Narrative description of the operation
   f. Major findings
   g. Complications
   h. Estimated blood loss
   i. Specimens

2. Discharge Summaries
   Dictated discharge summaries will be completed on all patients hospitalized for more than 48 hours, and for those trauma patients surviving less than 48 hours. Patients hospitalized less than 48 hours may have a ~~handwritten~~ typed or dictated discharge summary at the discretion of the treating resident or attending physician. Dictated discharge summaries will contain a succinct description of the reasons for hospitalization, the course of treatment, complications of treatment, condition on discharge, and plans for post-hospitalization care.

   As noted above, consistently delinquent operative or medical records may result in temporary or permanent loss of privileges as outlined in the Medical Staff Bylaws.

I. INFORMED CONSENT

1. All decisions for operative treatment should involve the active participation of the patient or their surrogate, and should be made after appropriate discussions of the details of the procedure and expectations

for the procedure, and attendant alternatives, risks, benefits, and complications.

2. Documentation of "Informed Consent" on medical staff approved forms is required for the following:
    a. All surgical procedures performed in the operating room, procedure rooms, ICU or wards.
    b. All procedures performed in the clinic unless specifically included on the list of procedures that do not require consent.
    c. All procedures involving laser therapy.
3. Documentation of patient consent will be provided by a properly signed and completed ZSFG~~H~~ Operative Consent Form.
4. The operating surgeon will also provide a Preoperative Note in the progress notes section of the patient ~~chart~~ EHR (typically the ~~on~~ pre- and post-operative note form). This note should included elements outlined in I.1. above.

X. MEETING REQUIREMENTS

A. MEETING CRITERIA

In accordance with ZSFG~~H~~ Medical Staff Bylaws, All Active members of the ZSFG~~H~~ medical staff are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, and the annual Medical Staff Meeting. This information will be located in the provider files.

Clinical Services (faculty) meetings are conducted at least twice monthly for the purpose of discussing clinical service needs, financial monitoring, educational and research agendas and other business as appropriate.

As defined in the ZSFG~~H~~ Medical Staff Bylaws, a quorum is constituted by at least three (3) voting members of the Active Staff for the purpose of conducting business.

B. COMMITTEES

Members of the Department of Surgery either Chair or participate in the following ZSFG~~H~~ committees

1. Multidisciplinary Trauma Peer Review Committee (TMD serves as Chair)
2. Hospital PIPS
3. Risk management
4. MEC (Chief and Trauma Director are ex officio members)
5. Disaster
6. Operating Room (Chief is ex officio member & co-chair)
7. Transfusion
8. Critical Care
9. PEMT
10. CPG

11. Credentials
12. Cancer
13. Others as needed
~~14. ...~~

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. OPERATIONAL

All house staff will receive, and are required to review, the online orientation module, “Surgical Resident Orientation to the Operating Room" (see Attachment C.5). All new faculty members will be oriented by the Chief of Surgery and have meetings scheduled to meet other key physician and nursing colleagues to assist in orientation to the hospital. The Chief of Surgery will be responsible for ensuring that 24-hour a day, 365 day-a-year attending and resident surgeon coverage is available for the hospital.

B. SCHEDULES

Full time faculty must submit their requests for time off to the Chief of Surgery at least two months ahead of time. Full time faculty must note on their schedule request reasons for days off (i.e. personal, reason for work-related business.)

All approved schedule requests will be kept on file with the scheduling administrative assistant. She/he will coordinate with the 3M and ISIS clinics and the OR regarding out of office faculty schedule blocking. Absence from clinic and release of OR time will not be accommodated (except in case of an emergency or illness) if the notification is shorter than ~~two months~~6 weeks in advance.

Once the trauma/service calendars are completed, it is up to the individual attending surgeon to find coverage should they wish to trade dates. In the event of an illness, the back-up surgeon will be call to provide in-house coverage until the schedule can be rearranged.

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C. CLINICAL

The evaluation and documentation of patients admitted to the hospital are discussed in section IX D and IX E.

D. RISK MANAGEMENT

The Chief of Service will ensure that hospital policies regarding leaving against medical advice, restraints, informed consent, DNR, universal precautions, and the use of interpreters are followed by members of the Surgery Service.

XII. ADOPTION AND AMENDMENT

The Surgery Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Surgery Service annually at a quarterly schedule Surgery Clinical Service meeting~~g~~.

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Surgery Privileges

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

Applicant: Please initial the privileges you are requesting in the Requested column.
Service Chief: Please initial the privileges you are approving in the Approved column.

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FOR ALL PRIVILEGES: All complication rates, including transfusions, deaths, unusual occurrence reports, patient complaints, and sentinel events, as well as Department quality indicators, will be monitored semiannually.

_____ _____ **38.00 CORE PRIVILEGES/GENERAL SURGERY**

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures
REAPPOINTMENT: 20 operative procedures in the previous two years

Preoperative, operative and post-operative care of patients Surgery of the alimentary tract, abdomen, breast, skin and soft tissues, and endocrine system. Privilege includes care of general surgical and trauma patients in the Intensive Care Unit, non-surgical or surgical management in the surgical clinic or emergency department, and comprehensive management of enteral and parenteral nutrition. Surgical procedures are:

_____ _____ 38.01 ABDOMEN, PERITONEUM
- _____ _____ A. Insertion Peritoneal Dialysis Catheter
- _____ _____ B. Open or Laparoscopic Exploratory Laparotomy
- _____ _____ C. Open Drainage Abdominal Abscess
- _____ _____ D. Open Repair of Inguinal, Femoral, and Ventral Hernia
- _____ _____ E. Laparoscopic Repair of Inguinal, Femoral, and Ventral Hernia
- _____ _____ F. Repair Miscellaneous Hernias

_____ _____ 38.02 ESOPHAGUS
- _____ _____ A. Laparoscopic Anti-Reflux Procedure
- _____ _____ B. Open Anti-Reflux Procedure or Repair of Paraesophageal Hernia

_____ _____ 38.03 LIVER, BILIARY TRACT, PANCREAS
- _____ _____ A. Open or Laparoscopic Cholecystectomy With or Without Cholangiography
- _____ _____ B. Cholecystostomy
- _____ _____ C. Open Common Bile Duct Exploration, Repair Acute Common Bile Duct Injury
- _____ _____ D. Choledochoscopy
- _____ _____ E. Choledochoenteric Anastomosis
- _____ _____ F. Operation for Gallbladder Cancer (when found incidentally)
- _____ _____ G. Hepatic Biopsy, Wedge Resection of Liver, Drainage Liver Abscess
- _____ _____ H. Distal Pancreatectomy or Pancreatic Debridement for Necrosis
- _____ _____ I. Intraoperative Pancreatic Ultrasound
- _____ _____ J. Drainage Pancreatic Pseudocyst

_____ _____ 38.04 STOMACH and INTESTINES
- _____ _____ A. Percutaneous Endoscopic Gastrostomy
- _____ _____ B. Partial/Total Gastrectomy
- _____ _____ C. Truncal Vagotomy and Drainage, Repair Duodenal Perforation, Open Gastrostomy
- _____ _____ D. Open or Laparoscopic Appendectomy

Privileges for Zuckerberg San Francisco General Hospital

Requested	Approved	
_____	_____	E. Open Partial Colectomy, Colostomy, Colostomy Closure
_____	_____	F. Subtotal Colectomy with Ileorectal Anastomosis/Ileostomy
_____	_____	G. Laparoscopic Partial Colectomy
_____	_____	H. Hemorrhoidectomy, Lateral Internal Sphincterotomy, Banding for Internal Hemorrhoids
_____	_____	I. Drainage Anorectal Abscess, Pilonidal Cystectomy, anal Fistulotomy/Seton Placement
_____	_____	38.05 ENDOCRINE SYSTEM
_____	_____	A. Partial or Total Thyroidectomy and Parathyroidectomy
_____	_____	B. Open Adrenalectomy
_____	_____	38.06 ENDOSCOPY
_____	_____	A. Esophagogastroduodenoscopy
_____	_____	B. Proctoscopy
_____	_____	C. Colonoscopy with or without Biopsy/Polypectomy
_____	_____	38.07 HEMIC and LYMPHATIC SYSTEMS
_____	_____	A. Open splenectomy
_____	_____	B. Lymph-Node Biopsy or Excision
_____	_____	C. Bone marrow Biopsy and Aspiration
_____	_____	38.08 SKIN and SOFT TISSUES
_____	_____	A. Excisional/Incisional Resection and/or Repair of Lesions of Skin and Subcutaneous Tissues.
_____	_____	B. Excision, Biopsy, Incision of Soft Tissue Lesion of Muscular or Fascial Areas
_____	_____	C. Incision, Drainage, Debridement for Soft Tissue Infections
_____	_____	D. Wide Local Excision Melanoma
_____	_____	E. Split-thickness and Full-thickness Skin Grafts
_____	_____	F. Burn Debridement
_____	_____	G. Repair of Wounds and Complex Lacerations and Traumatic Injuries
_____	_____	H. Repair Tendons
_____	_____	I. Digital Nerve Block
_____	_____	J. Fasciotomy
_____	_____	K. Placement of Negative Pressure Dressing Devices
_____	_____	38.09 CARDIOVASCULAR SYSTEM
_____	_____	A. Venous Insufficiency and Operation for Varicose Veins
_____	_____	B. Sclerotherapy, Peripheral Vein
_____	_____	C. Insertion of Vena Caval Filter
_____	_____	D. Percutaneous Vascular Access
_____	_____	E. Creation or Rrevision of Arteriovenous Graft/Fistula
_____	_____	F. Embolectomy/Thrombectomy Artery
_____	_____	G. Major Extremity Amputations (above or below knee, foot, transmetatarsal, toe)
_____	_____	38.10 THORAX
_____	_____	A. Chest Tube Placement
_____	_____	B. Exploratory Thoracotomy, Pericardial Window for Diagnosis/Drainage
_____	_____	38.11 TRACHEA and BRONCHI
_____	_____	A. Tracheostomy and Cricothyroidotomy
_____	_____	**38.20 SPECIAL PRIVILEGES**

Requested	Approved	
_____	_____	38.21 COMPLEX UPPER ABDOMINAL SURGERY PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or American Board of Cardiothoracic Surgery, or a member of the Clinical Service prior to 10/17/00 PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures. REAPPOINTMENT: 10 operative procedures in the previous 2 years. Preoperative, operative and post-operative care of patients with complex benign or malignant conditions of the esophagus, liver, and pancreas:
_____	_____	A. Total esophagectomy, esophagogastrectomy
_____	_____	B. Open Heller myotomy, Collis gastroplasty, resection of perforated esophagus
_____	_____	C. Cricopharyngeal myotomy with excision Zenker's diverticulum
_____	_____	D. Laparoscopic repair of paraesophageal hernia or Heller myotomy
_____	_____	E. Open liver segmentectomy/lobectomy
_____	_____	F. Laparoscopic liver segmentectomy/lobectomy
_____	_____	G. Portal-systemic shunt
_____	_____	H. Operation for gallbladder or bile duct cancer (planned)
_____	_____	I. Excision choledochal cyst
_____	_____	J. Pancreaticoduodenectomy, ampulary resection, or total pancreatectomy
_____	_____	K. , Frey procedure, Beger procedure
_____	_____	38.22 COMPREHENSIVE CARE OF BREAST DISEASE PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures. REAPPOINTMENT: 20 operative procedures in the previous 2 years. Preoperative, operative and post-operative care of patients with complex benign or malignant conditions (excluding soft tissue infections) of the breast:
_____	_____	A. Aspiration of breast cyst
_____	_____	B. Duct excision
_____	_____	C. Breast biopsy with or without needle localization
_____	_____	D. Lumpectomy, partial, simple mastectomy, modified radical, radical mastectomy
_____	_____	E. Sentinel lymph node biopsy, axillary lymph node dissection
_____	_____	F. Stereotactic breast biopsy
_____	_____	38.23 COMPLEX COLO-RECTAL SURGERY PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or American Board of Colorectal Surgery, or a member of the Clinical Service prior to 10/17/00. PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures. REAPPOINTMENT: 10 operative procedures in the previous 2 years. Preoperative, operative and post-operative care of patients with complex benign or malignant conditions of the colon and rectum:
_____	_____	A. Total proctocolectomy, ileoanal pull-through, ileal-pouch procedures

Requested	Approved	
_____	_____	B. Repair complex anorectal fistulae
_____	_____	C. Excision of anal cancer, transanal resection for tumor
_____	_____	D. Perineal operation for rectal prolapse
_____	_____	E. Stapled hemorrhoidectomy
_____	_____	F. Open or laparoscopic transabdominal operation for rectal prolapse
_____	_____	G. Abdominoperineal resection
_____	_____	H. Pelvic exenteration for rectal cancer
_____	_____	38.24 COMPLEX VASCULAR SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or Board Certification or eligibility in Vascular Surgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures.
REAPPOINTMENT: 10 operative procedures in the previous 2 years.

Preoperative, operative and post-operative care of patients with complicated vascular disease:

_____	_____	A. Aorto-iliac, ilio-femoral, aorto-femoral bypass
_____	_____	B. Femoral-femoral, femoral-popliteal, axillo-femoral bypass
_____	_____	C. Profunda endarterectomy, other endarterectomy
_____	_____	D. Infrapopliteal bypass, composite leg bypass graft, revise/re-do lower extremity bypass
_____	_____	E. Thoracic outlet decompression, vertebral artery operation, arm bypass, or endarterectomy
_____	_____	F. Celiac/SMA/renal endarterectomy/bypass
_____	_____	G. Elective repair aorto/iliac/femoral/popiteal aneurysm
_____	_____	H. Repair thoracoabdominal aortic aneurysm
_____	_____	I. Carotid endarterectomy, reoperative carotid surgery, excise carotid body tumor
_____	_____	J. Angioscopy
_____	_____	K. Balloon angioplasty, transcatheter stent
_____	_____	L. Endovascular repair other aneurysm, other endovascular graft
_____	_____	M. Endovascular thrombolysis
_____	_____	N. Pseudoaneurysm repair/injection
_____	_____	O. Excise infected vascular graft, repair graft-enteric fistula
_____	_____	P. Sympathectomy
_____	_____	Q. Venous embolectomy/thrombectomy, venous reconstruction
_____	_____	R. Repair arteriovenous malformation
_____	_____	38.25 COMPREHENSIVE PEDIATRIC SURGERY

PREREQUISITES: Currently Board Certified, or Re-Certified by the American Board of Pediatric Surgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures

_____	_____	A. Excision of retroperitoneal or pelvic tumor, including Wilms' tumor and neuroblastoma
_____	_____	B. Repair of complex chest and abdominal wall defect
_____	_____	C. Repair omphalocele or gastroschisis
_____	_____	D. Repair of esophageal atresia, stenosis or tracheo-esophageal fistula
_____	_____	E. Definitive surgery for Hirschsprung's Disease
_____	_____	F. Operation for rectal duplication
_____	_____	G. Repair of imperforate anus, including secondary operations

Requested	Approved		
_____	_____	H.	Operative reduction intussusception
_____	_____	I.	Pyloromyotomy
_____	_____	J.	Correction of congenital vaginal/penile anomalies, exploration and management of intersex
_____	_____	K.	Excision cystic hygroma, lymphangioma, hemangioma
_____	_____	L.	Excision of hemangiomas and lymphangiomas
_____	_____	M.	Repair of pectus excavatum, pectus carinatum and other thoracic deformities
_____	_____	N.	Excision intrathoracic tumor, cyst or other lesion, including mediastinum
_____	_____	O.	Segmental pulmonary resection, lobectomy, pneumonectomy
_____	_____	P.	Repair exstrophy of cloaca or vesicointestinal fissure, repair of cloacal anomaly
_____	_____	Q.	Nephrectomy, partial or complete for trauma or benign and malignant cyst or tumor
_____	_____	R.	Repair hypospadias or epispadias, meatotomy
_____	_____	S.	Nissen fundoplication
_____	_____	38.26	SURGICAL CRITICAL CARE

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery in Surgical Critical Care, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Review of 10 cases
REAPPOINTMENT: Provision of surgical critical care to a minimum of 20 patients and at least 10 hours of critical care – related CME in the previous 2 years

Critical care of patients hospitalized in Intensive Care Units, including (but not limited to) comprehensive management of mechanical ventilation, nutrition, cardiovascular support, diagnosis and management of infections, management of shock, critical care of neurologic and neurosurgical patients, critical care of burn patients. Performance of invasive critical care procedures:

_____	_____	A.	pulmonary artery catheter placement
_____	_____	B.	Endotracheal intubation, airway management
_____	_____	C.	Thoracentesis, paracentesis
_____	_____	D.	Patient controlled analgesia and epidural analgesia
_____	_____		
_____	_____	E.	Cardiac pacing (external and transvenous), defibrillation and cardioversion.
_____	_____	38.27	PLASTIC SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures
REAPPOINTMENT: 40 operative procedures in the previous two years

Functional and aesthetic management of congenital acquired and traumatic defects of the face, neck, body, and extremities, excluding microsurgery and replantation of limbs and parts

_____	_____	A.	Incision and Drainage of abscess
_____	_____	B.	Flexor/extensor tendon repair, tenolysis, drainage of tendon sheath
_____	_____	C.	Local skin/ muscle rotational flap, skin tissue rearrangement
_____	_____	D.	Repair nailbed injury
_____	_____	E.	Release a-1 pulley, pulley reconstruction

Requested	Approved		
_____	_____	F.	Fasciotomy
_____	_____	G.	Separation of digit syndactyly, excision of supranumery digit
_____	_____	H.	Carpal/cubital tunnel release
_____	_____	I.	Completion amputation of digit
_____	_____	J.	ORIF/CRPP radius, ulnar, carpal, metacarpal, phalangeal fractures
_____	_____	K.	Removal of foreign body
_____	_____	L.	Placement of tissue expander
_____	_____	M.	Breast reconstruction with TRAM, free perforator flap
_____	_____	N.	Breast capsulotomy/capsulectomy
_____	_____	O.	Breast reconstuction with saline implant, removal saline implants
_____	_____	P.	Nipple reconstuction
_____	_____	Q.	ORIF mandibulomaxillary/ZMC/nasal/nasoethmoid/orbital floor fracture
_____	_____	R.	Full thickness (FTSG) or split thickness skin graft (STSG)
_____	_____	S.	Abdominal wall reconstruction, components separation, mesh placement
_____	_____	T.	Debridement, skin and subcutaneous tissue, muscle and bone
_____	_____	U.	Placement of negative pressure dressing devices
_____	_____	38.28	MICROSURGERY AND REPLANTATION OF LIMBS AND PARTS

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery, or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with successful completion of a Fellowship in Microsurgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 2 observed operative procedures and 5 retrospective review of operative procedures
REAPPOINTMENT: 5 operative procedures in the previous two years

_____	_____	A.	Use of operating microscope, repair blood vessel/ nerve, digit replantation
_____	_____	B.	Free myo/skin flap microvascular anastamosis
_____	_____	38.29	LASER SURGERY

PREREQUISITES: Currently Board Admissible, Board Certifed, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Appropriate training, viewing of the laser safety video prepared by the SFGH Laser Safety Committee, and baseline eye examination.
PROCTORING: 2 observed procedures
REAPPOINTMENT: 2 cases in the previous two years; and viewing of the laser safety video prepared by the SFGH Laser Safety Committee and documentation of eye exam within the previous 6 months

_____	_____	A.	Removal of congenital and acquired lesions (tattoos, hemangiomas, pigmented lesions)
_____	_____	38.30	LAPAROSCOPIC GENERAL SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified or Re-certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Demonstration of competence in Laparoscopic Surgery and completion of a surgical residency/fellowship that incorporates structured experience in laparoscopic surgery. For those without formal training during residency or fellowship in laparoscopic procedures, the minimum requirements are: observation of a minimum of five (5) cases and successful completion of twenty-five (25) cases.
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 5 operative procedures in the previous two years

Privileges for San Francisco General Hospital

Requested	Approved	
_____	_____	A. Laparoscopic repair of paraesophageal hernia or Heller myotomy
_____	_____	B. Laparoscopic liver segmentectomy/lobectomy
_____	_____	C. Laparoscopic procedures for morbid obesity
_____	_____	D. Laparoscopic or lap-assisted colectomy
_____	_____	E. Laparoscopic assisted panceatectomy
_____	_____	F. Laparoscopic splenectomy
_____	_____	G. Laparoscopic adrenalectomy
		H. Other advanced laparoscopic procedures NOS
_____	_____	38.31 BRONCHOSCOPY AND FOREIGN BODY REMOVAL PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Surgery or American Board of Thoracic Surgery, or a member of the Clinical Service prior to 10/17/00. PROCTORING: 1 observed operative procedure REAPPOINTMENT: 2 cases in the previous two years
_____	_____	38.32 ACUTE TRAUMA CARE PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Current ATLS certification (provider). Availability, clinical performance and continuing medical education consistent with current standards for general surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons. PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures REAPPOINTMENT: 5 operative procedures in the previous two years. 32 hours of trauma-related CME in previous 2 years. On-call trauma coverage for the initial resuscitation and comprehensive management of the acutely injured patient. Includes acute operative management of thoracic and vascular injuries, and initial surgical critical care of the trauma patient:
_____	_____	A. Repair/resection for renal, ureteral, or bladder trauma
_____	_____	
_____	_____	
_____	_____	B. Placement of intracranial pressure monitor
_____	_____	C. Reduction and stabilization of maxillofacial fracture
_____	_____	D. Repair of tendon or nerve
_____	_____	E. Open reduction/ debridement of open/closed fracture, closed reduction of fracture

Requested	Approved		
_____	_____	38.33	PERCUTANEOUS DILITATIONAL TRACHEOSTOMY WITH BRONCHOSCOPIC ASSISTANCE Privilege shall be performed either in the Operating Room or in the ICU. All procedures will be performed with bronchoscopic guidance. PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Documentation of two successfully performed procedures supervised by an experienced practitioner or documentation of two previous successful procedures during residency or fellowship. PROCTORING: 1 observed operative procedure REAPPOINTMENT: 1 operative procedure in the previous two years
_____	_____	38.34	SURGICAL ULTRASOUND Examination for the detection of peritoneal or pericardial fluid PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery. Successful completion of a basic ultrasound course approved by the American College of Surgeons and successful completion of the advanced module for trauma and acute care imaging course. PROCTORING: Interpretation of 25 exams REAPPOINTMENT: Interpretation of 25 ultrasounds and 3-hours of Category I CME in ultrasonography in the previous two years
_____	_____	38.35	MODERATE SEDATION PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department PROCTORING: Review of 5 cases REAPPOINTMENT: Review of 5 cases or completion of the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department
_____	_____	38.36	NON-TRAUMA THORACIC SURGERY PREREQUISITES: Currently Board Admissable, Board Certified, or Re-Certified by the American Board of Cardiothoracic Surgery, or currently Board Admissable, Board Certified,or Recertified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00, or successful completion of a structured experience in thoracic surgery including the successful completion of twenty-five (25) cases. PROCTORING: 2 operative cases REAPPOINTMENT: 2 operative cases in the previous two years
_____	_____	A.	Pulmonary lobectomy, pneumonectomy, wedge lung resection
_____	_____	B.	Pleurodesis, open drainage of empyema
_____	_____	C.	Excision mediastinal tumor
_____	_____	D.	Transthoracic repair diaphragmatic hernia
_____	_____	E.	Repair aortic arch injury, dissection, or thoracic aortic aneurysm or dissection
_____	_____	F.	Pericardiectomy
_____	_____	G.	ORIF rib fractures

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

_____ _____ 38.37 THORACOSCOPIC SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or American Board of Cardiothoracic Surgery, or a member of the clinical service prior to 10/17/00, or completion of a surgical residency/fellowship that incorporates a structured experience in thoracoscopic surgery. Competence should be documented by instructors. For those without formal training during residency or fellowship in thoracoscopic procedures, the minimum requirements are observation of three thoracoscopic surgical procedures performed by a surgeon experienced in the performance of such procedures; and either training in thoracoscopic surgery by a surgeon experienced in thoracoscopic surgery with proctored assistance by a surgeon experienced in either thoracoscopic procedures or laparoscopic techniques, or completion of a University sponsored or academic society (Joint Committee) recognized didactic course with clinical and hands-on laboratory practice in three animals
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 1 operative procedure in the previous two years

_____ _____ A. Thoracoscopy with or without biopsy
_____ _____ B. Thoracoscopic pleurodesis, evacuation hematoma or empyema
_____ _____ C. Thoracoscopic Heller myotomy

38.38 CARDIOPULMONARY BYPASS

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified by the American Board of Cardiothoracic Surgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 2 operative procedures in the previous two years

_____ _____ 38.39 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery and current X-Ray/Fluoroscopy Certificate, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Presentation of valid California Fluoroscopy certificate;
REAPPOINTMENT: Presentation of valid California Fluoroscopy certificate

_____ _____ 38.40 COMPLEX CRANIOFACIAL SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 2 cases in the previous two years

_____ _____ A. Closed reduction and Mandibulomaxillary (MMF) fixation of mandible fracture
_____ _____ B. Open reduction and internal fixation of mandible fracture
_____ _____ C. Open reduction and internal fixation of zygoma fracture
_____ _____ D. Open reduction and internal fixation of orbital floor fracture
_____ _____ E. Open reduction and internal fixation of orbital wall fracture
_____ _____ F. Open reduction and internal fixation of zygomaticomaxillary (ZMC) complex fracture
_____ _____ G. Open reduction and internal fixation of noso-orbital ethmoid fracture
_____ _____ H. Open reduction and internal fixation of Le Fort I fracture
_____ _____ I. Open reduction and intenal fixation of Le Fort II fracture
_____ _____ J. Open reduction and internal fixation of Le Fort III fracture
_____ _____ K. Cleft lip repair
_____ _____ L. Cleft palate repair
_____ _____ M. Resection of arteriovenous malformation
_____ _____ N. Comlex tissue rearrangement, scalp

Requested Approved

_____ _____ 38.45 COMPLEX HAND SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery, or the American Board of Surgery with successful completion of a fellowship in Hand Surgery

PROCTORING: 1 observed operative procedures

REAPPOINTMENT: 2 cases in the previous two years

_____ _____ A. Incision/drainage abscess, finger or hand
_____ _____ B. Palmar fasciotomy Dupuytren's contracture
_____ _____ C. Palmar fasciectomy Dupuytren's contrature
_____ _____ D. Closed capsulotomy
_____ _____ E. Open capsulotomy
_____ _____ F. Exicsion Bone cysts
_____ _____ G. Excision bone tumors
_____ _____ H. Bone Grafts, hands or fingers
_____ _____ I. Arthrodeisis, hand or finger joints
_____ _____ J. Tenolysis
_____ _____ K. Tenorrhaphy
_____ _____ L. Tendon Transfer
_____ _____ M. Free Tendon graft, from arm or leg
_____ _____ N. Arthroplasty with implant
_____ _____ O. Ligament repair or reconstruction
_____ _____ P. Reconstruction Hand Deformities
_____ _____ Q. Amputation, finger, hand or forearm
_____ _____ R. Fractures/dislocations
_____ _____ S. Carpal tunnel release
_____ _____ T. Nerve tranpositions
_____ _____ U. Nerve repair, primary
_____ _____ V. Nerve repair, seondary with nerve graft
_____ _____ W. Removal of foreign bodies
_____ _____ X. Replantation of fingers and/or hand
_____ _____ Y. Wrist arthoscopy
_____ _____ Z. Carpal bone fractures
_____ _____ A1. Wrist Fractures

_____ _____ 38.55 WAIVED TESTING

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

_____ _____ A. Fecal Occult Blood Testing (Hemoccult®)
_____ _____ B. Vagnal pH Testing (pH Paper)
_____ _____ C. Urine Chemstrip® Testing
_____ _____ D. Urine Pregnancy Test (SP® Brand Rapid Test)

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

I hereby request clinical privileges as indicated above.

_____ _____
Applicant date

FOR DEPARTMENTAL USE:

_____ Proctors have been assigned for the newly granted privileges.
_____ Proctoring requirements have been satisfied.

_____ Medications requiring DEA certification may be prescribed by this provider.
_____ Medications requiring DEA certification will not be prescribed by this provider.

_____ CPR certification is required.
_____ CPR certification is not required.

APPROVED BY:

_____ _____
Division Chief date

_____ _____
Service Chief date

Appendix A. OR Block Time

MONDAY:

3.5 OR's available –, Plastic Surgery (Terry), General Surgery (~~Campbell, Wybourn~~Hill, Oskowitz), Vascular (1st and 3rd Mondays)

TUESDAY:

4 OR's available Colorectal/Minimally Invasive Surgery (1 – alternating weeks for each surgeon),
General Surgery (~~, , , , Juillard~~ Wybourn, ~~–~~) ~~(2), Vascular (dialysis shunts) every other week (OR block time to come from multiple sources including general surgery)~~
Plastic Surgery (Terry)
Breast Surgery

WEDNESDAY:

2 OR available Surgery (Sammann), Plastic Surgery (Rahgozar)

THURSDAY:

3.5 OR's available – Mackersie Campbell , Plastic Surgery (Young, Hansen, Terry)

FRIDAY:

1.5 OR's available – ~~Vascular~~Vartanian, ~~-~~ General Surgery

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APPENDIX B: SURGERY HOUSE STAFF COMPETENCIES

Refer to CHN Intranet site, House Staff Competencies link.

APPENDIX C – ADDITIONAL CLINICAL SERVICE SPECIFIC ATTACHMENTS

1. **ATTACHMENT C1: AFFILIATED PROFESSIONALS**
2. **ATTACHMENT C2: SURGERY CLINICAL SERVICE PROCTORING PLAN**
3. **ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN**
4. **ATTACHMENT C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL**
5. ~~5.~~ **ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY**
6. **ATTACHMENT D: JOB DESCRIPTIONS**

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APPENDIX C ATTACHMENT C1: AFFILIATED PROFESSIONALS

(TRAUMA NURSE PRACTITIONER BINDER KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX C: ATTACHMENT C2 - SURGERY CLINICAL SERVICE PROCTORING PLAN

SURGERY CLINCIAL SERVICE
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL PROCTORING PLAN

I. REQUIREMENTS

A Proctoring will be required who request surgical privileges within the Surgery Clinical Service at Zuckerberg San Francisco General Hospital. The proctoring which is carried out will be specific to the area in which privileges are requested.

C Applicants for surgical privileges at ZSFG~~H~~ who are accredited on the active staff at UCSF campus hospitals and UCSF affiliated hospitals (SFVAMC, CPC, Kaiser SF), have faculty appointments in the UCSF Department of Surgery, and perform the majority of their surgery at a UCSF campus hospital or UCSF affiliated hospital will be assumed to have been adequately proctored and will not be required to have direct observation on their cases in the operating room. Unless the Chief of Surgery determines that there is a reason for intraoperative proctoring.

D Proctoring will consist of these activities:

1. Intraoperative Observation
   Direct intraoperative observation of applicants will be carried out by one of the assigned proctors for a sufficient number of cases in each category of privileges to assure competence in the technical and operative aspects of surgery.

2. Complication Review
   All deaths and complications occurring in patients treated by the applicant during the provisional year of staff appointment will be tabulated, and the conclusions of the surgery D&C conference regarding the specific complication will be reviewed.

E. The proctor appointed for the applicant and the Chief of Surgery will meet periodically to review the above areas, and determine when to discontinue monitoring in areas D.1. and D.2., based on the number of cases and competence demonstrated. At any point in the proctoring process, if the proctor and the Chief of Surgery feel that the applicant is not qualified in a specific area, they may revoke provisional privileges in that area and shall notify the applicant and the Credentials Committee in writing of this action.

F Anyone performing general surgery can be placed under observation at any time when it is deemed indicated by (1) the Chief of Service, (2) the Credentials Committee, (3) the Medical Executive Committee, or (4) the Operating Room Committee. The duration of observation shall be at the discretion of the Chief of Service, and a report shall be made at the end of this time to the requesting committee.

II. APPOINTMENT AND RESPONSIBILITITES OF PROCTORS

A. Any member of the Department of Surgery, who is a member of the Active Staff, or member of the Courtesy Staff with a UCSF faculty appointment, may be appointed as a proctor. The proctor must be experienced in the areas being evaluated, but need not have the same Board Certification or subspecialty certification as the applicant.

B. One or more proctors will be appointed by the Chief of Surgery for each applicant. The Chief of Surgery may participate as a proctor or may independently evaluate any aspect of patient care performed by the applicant.

C. The applicant will notify one of the proctors of all cases scheduled during the proctoring period, so that they may arrange to be present during surgery, until the requirements of Section I, D.1. above, have been satisfied. The applicant may schedule surgery at his or her discretion and it will be the responsibility of the proctor to attend if he wishes.

D. A proctoring form for each operative observation will be completed by the proctor and submitted to and maintained by the Chief of Surgery. These will be kept in the applicant's clinical service credentials file and will be confidential as legally defined within hospital surgical Performance, Improvement and Patient Safety process.

APPENDIX C: ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

APPENDIX C: ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY

1. **The Faculty clinic absentee** window is set at ~~two months~~6 wee~~k~~s. In the event that the physician will not be available after the ~~two-month~~6 week window has passed for a non-emergent reason:

    a. When a faculty absentee form is filled out, the clinic staff is responsible for informing the faculty member and the Department Assigned Administrative Assistant of receipt of the absentee date/time via email.
    b. The Attending has to directly inform the clinic nursing director, and the chief of surgery in writing including the reason for missing clinic. A specific reason (academic, out of town, site visit commitment) must be given.
        i. Action plan as understood by clinic staff will be communicated back to faculty member and Department Assigned Administrative Assistant via email to include
            1. Date of expected absence
            2. Plan for alternative coverage/rescheduling
        ii. Faculty must make every attempt at obtaining coverage – either from another attending assigned to that clinic or by having another attending cover the patient load, OR
        iii. As an alternative, patients can be rescheduled to one of the two back flow clinics on Monday or Thursday PM for the following week. This will be first come first serve.
    ~~c. Clinics will be opened on a rolling two month basis starting in fall 2013. This new policy is currently being tested in two other 3M clinics and will be rolled out to all clinics once the new system has been tested to ensure patients are being tracked accordingly for follow up appointments outside of the two month window.~~
        ~~i. A 3M Call Center is currently being piloted as well.~~
        ~~ii. Regular feedback regarding the details of this pilot should be communicated on a frequent basis from the clinic staff to faculty via email so that pitfalls can be addressed during the process in an efficient manner.~~
2. **Faculty timeliness**:
    a. Service expectations are that the patients are roomed and ready to be seen by 9 AM/1 PM so that clinic can start immediately. The service expects the attending to be on time for clinic and if not the clinic will call the attending by 9:15 or 1:15. If no response from the attending they are to call the Chief of Service or designee.
3. **Attending surgeons will be automatically excused from clinic when they are covering the service or are assigned to the ICU.** This includes the ICU service ~~–~~ at UCSF Moffit ~~,and~~ VAMC and UCSF Mission Bay~~.~~
    a. Faculty who need to see patients should use Monday afternoon overflow clinic time during the following week.
4. **Clinic Room Assignment:**
    a. NP's will use the room in the back of the clinic to complete H&P's.
    b. ~~As part of the FY 2014 budget,~~ MEA's have been proposed to help staff the rooms and will be assigned to specific rooms to help with patient throughput.
    c. ~~MEA with particular language skills will be expected to help flow and optimize caring service by being available for translation. This avoids the 20 minute waits for translator phones and adds a "face" to our care.~~
~~5.~~ **H&P's**: If the day of surgery is within 30 days of the last clinic visit, an interim H&P update is completed by the surgical attending or resident in the pre-operative area. In the event that surgery is > 30 days from the last clinic visit, a full H&P is to be completed by a member of the surgical

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team. ~~are in the process of being moved to the Pre-op Clinics. Staffing shortages have prevented this from happening more quickly. In the interim:~~

~~a. M, TR, F clinics: NPs or interns/residents assigned to clinic will do H&Ps.~~
~~b. Breast Clinic: NP will do H&P's~~
~~c. Vascular clinic: NP will do H&P's~~
~~d. H&P's will no longer be scheduled under a physician template. A new template will be opened called "NP – Only". This will be used to schedule H&P's at all times – regardless if the physicians are in clinic or not. This will prevent the physician's template from being used when he/she is not in attendance.~~

~~e.~~5. ~~All H&P pre-op "no-show" patients will have their surgeries cancelled immediately. Faculty will be notified at clinic that a slot has become available and each physician should work with the clinic staff to fill that slot accordingly.~~

6. Block time in the OR:

a. OR blocks may only be released by the attending assigned to that block. This should be done as soon as the attending knows she/he will be unavailable (on service; out of town etc). In general, these blocks ~~will~~ should be released two months ahead of time. Once the OR time has been released, the clinic OR calendar will clearly state that the time has been released. Once released it cannot be reclaimed.
    i. Other attendings may not schedule surgeries on a block day that is not theirs unless it has been released.
    ii. See appendix A for OR block schedule.

~~7. **General Surgery Open Access clinics** are held on Monday PM and Thursday PM.~~
~~a. Attending may utilize overflow clinic block times on a first come first serve basis. There are a limited number of rooms in these clinics which will prevent a full patient load.~~
~~b. The Surgery Chief Resident is expected to attend the Monday PM clinic~~.

~~8.~~7. **Scheduling templates:**

a. Each Faculty will be assigned a template designed by attending with an expectation that they will see between 5-10 new patients per week in general surgery and a similar number of followups. However, some attendings are only part-time and may see fewer patients. ~~Note: The patients scheduled for H&Ps are not included in this count since they are now under the NP template.~~

~~9.~~8. **Additional Scheduling Notes:**

a. Patients who fail to show up for their H&P's two weeks prior to surgery will be cancelled from the scheduled surgery. The clinic staff will immediately communicate with the faculty member about this cancellation so that another patient on the "blue list" can be placed in this slot. If that faculty member is not able to be reached, that slot will be opened up for inpatient overflow or other elective cases.

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~~**Appendix A. OR Block Time**~~

~~**MONDAY:**~~

~~**2 OR's available – Breast, Thoracic(1)**~~

~~**TUESDAY:**~~

~~**3 OR's available – Colorectal/Minimally Invasive Surgery (1 – alternating weeks for each surgeon), General Surgery (Muskat, Dicker, Cohen, Callcut, Juillard) (2), Vascular (dialysis shunts) every other week (OR block time to come from multiple sources including general surgery)**~~

~~**WEDNESDAY:**~~

~~**1 OR available, PM Only – Open Access**~~

~~**THURSDAY:**~~

~~**2 OR's available – Mackersie (1), Campbell (1)**~~

~~**FRIDAY:**~~

~~**2 OR's available – Vascular (1), General Surgery(1)**~~

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SURGERY CLINICAL SERVICE

PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

I. ORGANIZATION

The Surgery Clinical Service at Zuckerberg San Francisco General Hospital, under the umbrella of the hospital-wide Surgical Performance, Improvement and Patient Safety Committee, operates a quality management program within the Surgery Clinical Service with multiple facets. These activities, to be described below, are carried out under the direction of the Chief of Surgery. They, in turn, report to the ZSFG~~H~~ Surgical Performance, Improvement and Patient Safety Management Committee.

II. PURPOSE

The overall purpose of the Surgical Performance, Improvement and Patient Safety Committee is to (1) continuously monitor feedback and (2) ultimately improve the quality of patient care delivered by the Surgery Clinical Service. Monitoring exists for both surgical and resident staff, in addition to system monitoring for the Trauma Service. The intent of this monitoring is to identify and correct specific individual and system problems.

III. SCOPE

The services, which are included within this program, are the Trauma (which include General Surgery, Thoracic Surgery and Vascular Surgery), and Plastic Surgery Services. Oversight of the Plastic Surgery Surgical Performance, Improvement and Patient Safety program is delegated to the Chief of the Division of Plastic Surgery. Oversight of the other service is by the Chief of Surgery. Orthopedics, Neurosurgery, Urology, Otolaryngology (ENT), and Ophthalmology are not included within the Surgery Clinical Service and are responsible for the independent operation of their programs.

IV. IDENTIFICATION OF PROBLEMS

Three general methods are used to identify and correct problems that occur within a busy teaching hospital environment. These are as follows:

A. Routine Surveillance

The activities grouped under this heading are carried out as continuous activities for monitoring and ensuring the quality of care, and providing optimal teaching to students and residents.

1. Daily Attending Ward Rounds

   Ward rounds are made by surgical attendings with senior or chief residents on every service and every patient is seen and evaluated daily. Diagnostic and treatment plans, and clinical course are reviewed. A daily progress note is generated by each attending on every patient~~, and these typed notes are placed in the progress notes of the chart~~ and filed in the electronic medical record.

2. Daily Trauma Nurse Clinical Rounds

   An experienced Emergency/Trauma Nurse (most often the Trauma Program Coordinator or Trauma Case Manager) rounds daily with the Trauma Service Residents and collects data concurrently regarding diagnosis and treatment of trauma patients. Specific patient complications, as well as system problems (E.g., missed triage, delay in trauma team activation, etc.) are

tabulated and reported back to the Trauma Director. Patient complications are also reported by the resident staff at a weekly Service meeting. Data collected by the Trauma Program Coordinator is entered into the computerized Trauma Registry and analyzed for discrepancies in predicted vs. observed outcome as described below.

3. Surgical Mortality and Morbidity Conference
   This conference is held biweekly and all available Surgery Clinical Service attendings and residents attend. Weekly statistics are reviewed and all deaths and complications are reported and discussed. All deaths and complications are then entered in the computerized departmental registry and are categorized as preventable, possibly preventable, non-preventable, or systems problem according to responsible attending and resident for later compilation and analysis. In addition, complications or deaths are assigned a Severity Index (SI) rating on a 5 point scale as follows:
   SI-1: minor inconvenience. (Examples: superficial surgical site infection, pneumonia, UTI, uncomplicated missed injury)
   SI-2: moderate severity, slight prolongation hospital stay. (Examples: DVT requiring Coumadin, deep SSI requiring percutaneous drainage, iatrogenic pneumothorax)
   SI-3: complication associated with prolonged stay, need for readmission or additional procedures or interventions. (Examples: wound dehiscence, respiratory arrest, pulmonary embolus, post-operative bleeding requiring reoperation.)
   SI-4: Complication requiring major intervention, associated with prolonged morbidity or inconvenience. (Examples: Enteroatmospheric fistula, reoperation requiring ostomy, multiple additional procedures or admissions)
   SI-5: Long term or permanent morbidity, disability, or death.(Examples: Death, major amputation, permanent brain injury).

4. Monitoring of Incomplete ~~Charts~~ medical records and Undictated Operative Notes
   All surgical ~~charts~~ medical records of discharged patients from the preceding week are prepared by Medical Records weekly and are reviewed by the Surgery Clinical Service residents and attendings. All incomplete entries, unsigned medical student notes or orders, or absent discharge summaries are completed in the medical record~~.~~

   An independent system is used for completion of operative notes. The Medical Records Department notified the Chief of Surgery weekly with a written list of all incomplete operative notes. The Chief of Surgery directly contacts the responsible individual to ensure timely completion of the dictation.

B. Exception Reporting
The second method of identification of problems is via the reporting or unusual or unexpected occurrences. These problems are then individually investigated and evaluated and are referred to the Chief of Service or Trauma Director/Trauma QA Committee for resolution.

1. Unusual Occurrence Report
   Incident reports are completed by the nursing staff according to a set of defined indicators (e.g., drug reaction, patient complaint, unexpected return to the operating room, post-operative bleeding, etc) and these are channeled to the Chief of Surgery when any surgical patient or surgical staff is involved with the incident. These are individually investigated and either resolved or referred to the most appropriate body for resolution.

2. Interdepartmental Incidents
   System problems arising on surgical units between Services, etc. not requiring specific Unusual Occurrence Reports, are reported back to the Trauma Program Coordinator by faculty, residents, or nursing/ancillary personnel. This reporting system is in addition to routine surveillance made by the Trauma Program Coordinator as described previously. Specific problems are then forwarded to either the Chief of Surgery or the Trauma Director/Trauma PIPS Committee for discussion/resolution.

C. Use of Clinical Indicators
With the advent of the clinical ~~registry~~ EHR of all surgical patients, it has become possible to greatly expand the scope of this activity and identify attending-specific information related to patient outcomes. This activity is steadily evolving as more information is accumulated in the registry. The following are indicators currently in place.

1. Surgical Site Infections (General and Plastic Surgery)
   Overall wound infection rates are monitored by the Infection Control Committee and reported to the Chief of Surgery. These are attending specifics and may be discussed at the weekly Morbidity and Mortality Conference.

2. Attending Specific Compilation of Deaths and Complications (General Surgery)
   Aggregate compilation of deaths and complications on a quarterly basis for each attending surgeon are complied and reviewed by the departmental staff quarterly, in order to allow inter-attending comparison of rates.

3. Trauma Attending Presence at 900 Trauma Activations
   Expectation of ACS Trauma Center Verification is that a surgical attending will respond to highest level trauma activations within 15 minutes of the patient's arrival in the ED. ~~M~~m~~onitored~~ by the Trauma Medical Director as part of trauma PIPS process.

4. Unexplained Return to the Operating Room
   Information reported at M&M conference will be compiled to determine surgeon specific rates.

V. PROBLEM RESOLUTION

Resolution of problems identified by the above mechanisms occurs on multiple levels, as seems most appropriate to the individual circumstances. The principal methods are the following:

A. Individual Discussion
Minor problems related to individual behavior, administrative problems, and interpersonal or communication problems are best dealt with on an individual level. This is done by the Attending Surgeon on a given service in the process of daily contact and patient surveillance described above. Unusual problems are brought to the attention of the Chief of Surgery, who discusses the problem(s) with the individual(s) involved, when they are in the Surgery Clinical Service. Similar problems involving nursing personnel are dealt with by the Trauma Nurse Coordinator either through the Head Nurse of the Unit involved, or the individual nurse.

B. Group Discussion/Education –Surgery M&M Conference
The most common mechanism for evaluating and correcting problems in a teaching environment is through the constant education of the trainees involved in the process. This is accomplished as a significant part of the weekly Mortality and Morbidity Conference, in which the problems are identified, and then discussed in detail as to methods of avoidance or prevention. Expected standards of care, standards of monitoring, priority setting, methods of assessment, etc., are communicated to all levels of resident staffs.

C. Trauma Surgical Performance, Improvement and Patient Safety Committee
This conference is attended by representatives from all clinical services involved in the care of the trauma patient, as well as from nursing, and interdepartmental issues, policy changes, pre-hospital care issues, and more global institutional issues are addressed at this committee. The primary function of the Trauma PIPS Committee is to formulate and implement policy in response to system problems that arise and are identified by the methods described above. The clinical indicators specific to trauma patients are also reported back to this Committee. Trauma PIPS meeting is conducted by the Trauma Director who also sits on the Hospital Trauma PIPS Committee as a surgical representative.

~~Peter Muskat, MD~~
~~Chief of Surgery~~

APPENDIX C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL

(KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX D: JOB DESCRIPTIONS

CHIEF OF SURGERY CLINICAL SERVICE JOB DESCRIPTION

Chief of Surgery Clinical Service

Position Summary:

The Chief of Surgery Clinical Service directs and coordinated the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFGH) and the Department of Public Health (DPH). The Chief also insures that the Service's functions are integrated with those of other clinical departments and with the Hospital as a whole.

Reporting Relationships:

The Chief of Surgery Clinical Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the ZSFG~~H~~ Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of Surgery Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at SFGH.

Major Responsibilities:

The major responsibilities of the Chief of Surgery Clinical Service include the following:

Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of ZSFG~~H~~ and the DPH;

In collaboration with the Executive Administrator and other ZSFG~~H~~ leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;

In collaboration with the Executive Administrator and other ZSFG~~H~~ leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of

service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs.

Performing all other duties and functions spelled out in the ZSFGH Medical Staff Bylaws.

TRAUMA PROGRAM MEDICAL DIRECTOR

General Description:

The trauma medical director is a general surgeon, appointed by the Hospital through the Executive Administrator, to lead the multidisciplinary activities of the Trauma Program. The role of the TMD will be to work with service Chiefs and hospital administration in order to organize, manage, and develop the Trauma Program, and to seek to improve the Trauma Center in terms of quality, volume, scope of services, and cost-effectiveness of trauma care.

Qualifications:

- Current ABMS board certification in General Surgery.
- Fellow in good standing of the American College of Surgeons (ACS).
- Member in good standing of active medical staff, ZSFG~~H~~.
- Advanced competency and special interest in trauma care and surgical critical care.
- Active involvement in clinical trauma care and surgical critical care.
- Active involvement in regional or national trauma education.
- Active involvement/participation in regional & national trauma organizations.
- Active involvement and demonstrated proficiency in trauma-related research.
- Demonstrated leadership skills & established history of positive collegial relationships with professional and ancillary staff in an acute care environment.
- Minimum of three years prior experience in an established designated trauma center or system.
- Demonstrated leadership in peer-review committee functions for 'sentinel' or 'critical' case review.
- Demonstrated commitment to the underlying principles of Trauma Performance Improvement, Trauma Program requirements by the ACS Committee on Trauma and Title 22, and the process of trauma program verification and designation.

Appointment, reappointment, review, termination

- Appointed by the ZSFG~~H~~ Executive Administrator, in collaboration with the Chief of Surgery.
- Requires approval of Department Chair .
- Requires approval of the majority of the M~~T~~EC Chiefs of Services.
- Term of appointment three years.
- TMD performance review conducted every three years by the MEC. More often at the direction of the ZSFG~~H~~ Executive Administrator.
- The TMD may be removed by the Chief of Surgery, the Department Chair, or the ZSFG~~H~~ Executive Administrator in conjunction with a majority of MEC Chiefs of Service.

Responsibilities:

1) General Administrative Responsibilities and reporting relationships

- Directs the multidisciplinary functions of the trauma program.
- Provides the medical liaison between trauma team members and hospital administration.
- Responsible for ensuring that the quality of trauma patient care provided at ZSFG~~H~~ is commensurate with the institution's designation as a Level 1 center and as the sole provider of trauma services to the City & County of San Francisco.

- Takes action to correct deficiencies in coverage, response, or competence in the provision of trauma care by members of the trauma panel and trauma team.
- Regularly provides reports on Trauma Program performance to the MEC, including topics and issues related to policy, operations, staffing, quality improvement, and compliance with the Trauma Performance Agreement.
- Helps develop institutional policies, procedures and protocols, as needed, to improve the quality and cost-effectiveness of trauma care.
- Acts to further develop and promote the ZSFG~~H~~ trauma program as a regional resource.
- Acts as the principal clinical supervisor for the Trauma Program Nurse Practitioners.
- Reports directly to the ZSFG~~H~~ Executive Administrator.
- Collaborates with other Hospital Administrators, Chief of Staff, and Chiefs of Service.
- Monitors compliance with trauma performance agreement.
- Participates in CHN strategic planning.

2) Performance Improvement (PI) program

- Ensures that appropriate peer review is conducted for all types of adverse or potentially adverse event.
- Chairs Multidisciplinary Peer Review Committee.
- Helps develop clinical practice guidelines.
- Monitors as needed and makes recommendations regarding trauma-related hospital privileges and credentials for members of the trauma team.
- Monitors, as needed, facility standards to ensure that they are commensurate with Level 1 Center function.
- Reports matters of critical importance related to trauma patient care, as needed, directly to other administrative agencies or officers within the Department of Public Health or related CCSF agencies (e.g. SFPD, SFFD).

3) Trauma Center designation & verification

- Interacts with SF EMSA in reviewing Trauma Center performance consistent with the requirements in Title 22.
- Works with SF EMSA in revising, as needed, the CCSF Trauma Plan.
- Directs planning and preparation for ACS-COT Trauma Center site surveys and any additional site surveys that the local EMSA may require.

4) Trauma Registry

- Maintains control / oversight of Trauma Registry in conjunction w/ hospital administration.
- Responsible for overseeing timely updates of same.
- Establishes guidelines for use of ZSFG~~H~~ Trauma Registry data outside the Trauma Program.
- Reviews and approves written requests for registry data use by individuals or departments.

5) Credentialing / privileges

- Reviews, as needed, the performance and qualifications of Trauma Surgeons & members of the trauma team providing trauma care at ZSFG~~H~~.
- Adds/removes trauma surgeons from trauma panel, subject to the approval by TEC.
- Acts to restrict or suspend trauma-related privileges, as necessary and for just cause, in conjunction with the TEC, for any member of the trauma team.

- Recommends and/or approves recommendation, as indicated, for trauma privileges for members of the trauma team.

6) Pre-hospital care

- Involved in review/development of pre-hospital policies, practices, and procedures.
- Meets regularly w/ EMSA director, paramedic medical director & paramedics, as needed for purposes of: 1) City disaster planning, 2) Trauma triage, 3) Title 22 compliance, 4) Trauma system performance improvement, 5) Pre-hospital performance improvement.

7) Prevention

- Identifies a member of the trauma team or trauma panel who acts to coordinate injury prevention at ZSFG~~H~~.
- Monitors and acts to promote/enhance injury prevention activities at ZSFG~~H~~.
- Acts as a liaison and/or consultant for the Dept. of Public Health for purposes of organizing and promoting injury prevention programs and activities.

8) Patient & Community relations (outreach)

- Helps support & develop trauma patient/family satisfaction projects.
- Develops strategic relationships with referring hospitals & physicians for purposes of improving trauma care and facilitating any requested transfers.
- Supports and helps to provide provider educational offerings within the region.
- Participates in regional trauma audit committees as needed.
- Helps to develop and provide trauma consulting services, as needed, to surrounding communities.

9) Trauma Education / training / research

- Actively supports and participates trauma-related research and educational programs including those for medical students, residency programs, and post-graduate education.
- Participates in regional trauma audit committees as needed.
- Is actively involved in ATLS courses.

10) Participation at regional & national level (per ACS)

- Participates in local, regional, and national trauma-related activities and organizations.
- Participates in the trauma activities of the American College of Surgeons Committee on Trauma.

11) Managerial / Financial

- Works with trauma business mgr. & senior administrator to effect improvement in LOS, cost effectiveness as needed
- Implements policy/practice changes to help improve cost effectiveness.
- Ensures establishment of appropriate call schedules for all specialties.
- Assists TP manager in developing/meeting budgetary goals.

INTENSIVE CARE UNIT MEDICAL DIRECTORS
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
JOB DESCRIPTION

The ~~5E/5R and 4E~~ Medical Directors are physician leaders in critical care responsible for coordinating clinical care, clinical operations, and education and training in alignment with Zuckerberg San Francisco General Hospital's mission, vision, values and goals. The unit Medical Directors report to the ZSFG~~H~~ Critical Care Medical Director (CCMD) and work closely with the mangers of nursing and other allied healthcare professions to implement strategies for optimizing patient care and operational efficiency.

MISSION STATEMENT

The Medical Directors are committed leaders in continuous clinical innovation, quality improvement, and excellence in medical education.

QUALIFICATIONS

Board-certified in a relevant specialty as well as Critical Care Medicine
Credentialed ZSFG~~H~~ physician or eligible for such credentialing
Excited and inspired by the opportunity to make changes and improve systems
Strong commitment to the mission statement and responsibilities of the position
Outstanding professional credibility and personal integrity
Exceptional clinical skills
Demonstrated ability for teamwork and collaborative problem-solving using an analytical and systematic approach
Excellent verbal and written communication skills
Ability to provide leadership to physicians and other health care professionals

DUTIES AND RESPONSIBILITIES

XIII. Reporting Relationships

- Although the Medical Directors are full-time UCSF faculty members with an appointment within an academic department, in this position they report directly to the ZSFG ~~H~~ Critical Care Medical Director
- The Medical Directors work in close partnership with the other ICU Medical Directors and the ZSFG~~H~~ Critical Care Medical Director
- The Medical Directors work collaboratively with the ICU faculty and inter-disciplinary ICU care team

Performance Improvement and Patient Safety

- Develop and implement clinical protocols and quality improvement projects
- Review potential ICU-wide projects in the Critical Care Directors meetings
- Monitor the performance of the various protocols and analyze the results for further improvement
- Review relevant clinical quality data and performance measures and share findings to the ZSFG~~H~~ Critical Care Medical Director monthly
- Review and address major adverse events, near-misses, and patient safety vulnerabilities and coordinate Morbidity & Mortality Conferences

Clinical Operations

- Ensure adequate critical care physician staffing of intensive care units
- Coordinate call schedules for ICU faculty, fellows, and residents
- Assist the ZSFG~~H~~ Critical Care Medicine Director in optimizing patient flow in all ICU beds, coordinating with the Emergency Department, inpatient units, Operating Room, and Post-Anesthesia Care Unit
- Assist ZSFG~~H~~ Critical Care Medical Director in standardization and analysis of compliance in documentation, billing practices, and financial analysis of ICU operations
- Work with ICU nursing and hospital leadership to assure compliance with all regulatory requirements

Leadership and Communication

- Meet monthly with the ICU nurse manager and other healthcare professional leaders in the ICU to ensure close collaboration, coordination, and clear communication
- Meet monthly with the ZSFG~~H~~ Critical Care Medical Director and other ICU Medical Directors to standardize and coordinate care among all critical care units
- Participate in scheduled unit-specific ICU faculty meetings
- Participate in quarterly combined ICU faculty meetings
- Attend Quarterly ICU multi-disciplinary Grand Rounds
- Host and coordinate one ICU multi-disciplinary Grand Rounds per academic year
- Co-lead annual ICU faculty retreat
- Initiate and lead recurring multi-disciplinary Quality Improvement reviews in partnership with other services (ED, Trauma Surgery, Anesthesia, Family Medicine, Medicine, Otolaryngology, etc.)
- ~~Strategic planning: participate in planning and staffing for ICU beds and services related to the SFGH rebuild~~

Supervision of ICU Faculty

- Review clinical and teaching performance of individual Attendings and provide regular feedback, including compliance with protocols, promptness on rounds, and completion of teaching evaluations
- Ensure participation in quality improvement initiatives and adherence to standardized practices
- Set expectations and ensure Attending adherence to professional behavior standards at all times
- Ensure satisfactory Attending participation at various ICU faculty meetings and Grand Rounds

Medical Education (as applicable to the individual units)

- Resident and Fellow scheduling
- Serve as Medical Student Clerkship Director
- Coordinate Resident and Student evaluations
- Coordinate Journal Club, didactic teaching sessions, and other educational activities

Some duties above may be delegated with the understanding that the Medical Director is responsible for ensuring all tasks are completed.

Committees

All Medical Directors serve on a minimum of two Medical Staff committees, assigned upon mutual agreement with the ZSFG~~H~~ Critical Care Medical Director, including, but not limited to:

- Critical Care Committee
- Procedural Sedation Subcommittee of Pharmacy & Therapeutics Committee
- Trauma Peer Review Committee
- Performance Improvement and Patient Safety Committee
- Donor Committee
- Code Blue Committee
- Ethics Committee

Time Commitment

The Medical Director positions are 0.2 FTE commitment for each for the Medical and Surgical ICUs. When there are Co-Directors, duties are divided evenly and the expected effort is 0.1 FTE each. Division of responsibility is negotiated between the Co-Directors with the ZSFG~~H~~ Critical Care Medical Director and specific duties are clearly delineated.

Term of Appointment

The term of appointment as ICU Medical Director is one year subject to annual renewal based on satisfactory performance of the physician in this role and the needs of ZSFG~~H~~. There is an initial evaluation after the first 6 months of appointment and annually thereafter. Review is performed jointly by the ZSFG~~H~~ Critical Care Medical Director and Chief Medical Officer. Consideration of non-renewal of appointment will be discussed in advance with the faculty member's Service Chief.

~~See new form approved earlier this year~~