



# Rules and Regulations

Department of  
Surgery

## Table of Content

I. ORGANIZATION .....	3
II. MEMBERSHIP.....	3
III. CONDUCT .....	3
IV. SURGERY ADVISORY COMMITTEE .....	4
V. PRIVILEGES.....	4
VI. OBSERVATION REQUIREMENTS .....	4
VII. DUTIES AND RESPONSIBILITIES .....	5
VIII. SCOPE OF CARE AND SERVICE .....	6

# Pacific Hospital of Long Beach

## DEPARTMENT OF SURGERY

### Rules and Regulations

#### I. ORGANIZATION

A. Name:

The name of this organization shall be the Department of Surgery of the Medical Staff of Pacific Hospital of Long Beach. The Department is established as provided in the Medical Staff Bylaws.

B. Composition:

The Department of Surgery shall be composed of the sections of general surgery and anesthesia, which shall include specialties of:

General Surgery	Otololaryngology
Urology	General Dentistry
Orthopedics	Oral Surgery
Cardiovascular/Thoracic Surgery	Podiatry
Pathology	Vascular Surgery
Radiology	Plastic Surgery
Neurosurgery	Anesthesia
Pain Management	Ophthalmology

#### II. MEMBERSHIP

A. Qualifications:

A Physician (MD, DO), dentist, podiatrist, radiologist, pathologist or anesthesiologist may be a member of the Department of Surgery. Other subspecialties may become members as determined by the Department, with approval by the Medical Executive Committee and the Board of Directors. A certified registered Nurse Anesthetist or Registered Nurse First Assistant may be appointed to the Allied Health Professional category and hold privileges in the Department of Surgery. Other non-physician providers may be permitted to request membership in the AHP category with privileges in the Department of Surgery when deemed appropriate by the Surgery Department, and approved by the Medical Executive Committee and Board of Directors.

All members must first qualify for membership and clinical privileges as defined in Article II of the Bylaws of the Medical Staff of Pacific Hospital of Long Beach.

B. Appointments

New members recommended for provisional status by the Department of Surgery must also have the approval of the Medical Executive Committee and Board of Directors pursuant to the Medical Staff Bylaws.

The initial term of appointment shall be provisional in nature and in accordance with the Medical Staff Bylaws.

#### III. CONDUCT

A. Ethics:

The professional ethics of the members of the Department of Surgery shall be governed by the Bylaws, Rules and Regulations and Policies of the Medical Staff.

- B. Discipline:  
Evaluation of the surgical care rendered patient by members of the Department of Surgery shall be the concern of the Surgery Department. Matters involving discipline not satisfactorily resolved by the Surgical Department shall be as prescribed in Article VI of the Medical Staff Bylaws.
- C. Consultations:  
Consultation requirements will be as outlined in the Medical Staff Bylaws and Rules and Regulations.

#### IV. DEPARTMENT MEETINGS

The Department of Surgery/Anesthesia will meet quarterly.

#### V. PRIVILEGES

- A. Privileges:  
Privileges will be granted by the Surgery Department in accordance with Article V of the Medical Staff Bylaws. Criteria for granting privileges to perform special procedures will be contained in the Medical Staff Policy Manual, which is a part of the Bylaws and Rules and Regulations of the Medical Staff.

#### VI. OBSERVATION REQUIREMENTS

- A. Proctoring:  
Following accepted practice, the Surgery Department shall appoint a proctor for each physician on provisional status, temporary privileges, and those seeking modification or additional privileges. The applicant is responsible for arranging for his/her proctor/s to be available to observe the procedures. Proctoring guidelines are as follows:
  1. Proctoring shall be accomplished by direct concurrent observation if at all possible. Retrospective review may also be conducted. Cases that are peer reviewed by the department may also be considered as a proctored case.
  2. A minimum of three (3) major representative cases must be observed. An additional number of cases may be required if the Department Chair feels that additional proctoring is required.
  3. The proctor shall observe a variety of cases, based upon the privileges requested by the physician.
  4. The proctor shall complete proctor/evaluation forms which include the type of case, as well as an evaluation of the performance of the individual being proctored and submit the evaluation reports to the Medical Staff Office.
  5. Proctors must have sufficient training and expertise, and must be of the same specialty, to judge the quality of work being performed by the proctoree.
  6. State or County medical societies should be consulted for guidance in obtaining a proctor if there are no members qualified to proctor.
  7. The utilization of more than one proctor shall be encouraged. Except in extraordinary circumstances, associates shall not proctor each other.

8. Proctor/evaluation reports shall be reviewed by the Department Chief at the time of advancement from Provisional status to appropriate staff category, and recommendations shall be submitted to Credentials Committee and MEC to either discontinue or continue proctoring.
9. Proctoring evaluation reports are confidential and shall be maintained in the practitioner's credentials file.

## VII. DUTIES AND RESPONSIBILITIES

### A. General rules:

1. Preoperative work up for the patient, including chest x-rays, EKG's, pulmonary function studies, etc., will be left to the discretion of the attending physician or surgeon.
2. A preoperative note is required and shall be documented on the chart prior to all surgeries to include: diagnosis, procedure to be performed, clinical systems, pertinent clinical exam findings, diagnostic/therapeutic treatments and informed consent.
3. History and physicals for any inpatient procedure shall be dictated and placed on the chart prior to surgery. If the report is dictated but not on the chart prior to surgery, there must be a complete, comprehensive, and detailed admission note or complete, comprehensive and written history and physical written in the chart or by using the History and Physical for Outpatient Surgery form. The note must contain pertinent findings or sufficient patient information within 24 hours of admission so that clinicians can manage the patient and guide the plan of care.
4. Surgeons shall be in the hospital so as to begin operating promptly at the time scheduled for the procedure. In the event the surgeon is more than fifteen (15) minutes late in arriving for an operation, he/she shall yield the time to the surgeon scheduled to follow that case and will have the time of his/her case rescheduled by the nurse in charge of the Operating Room. Anesthetic shall not be started until the operating surgeon is present in the Operating Room Suite.
5. Postoperative orders must be written immediately upon completion of the procedure and before the surgeon leaves the Operating Room area. All standing preoperative orders are automatically canceled at the time of surgery and must be rewritten to remain in effect. All post Recovery Room orders, shall be written by the managing surgeon until discharged unless otherwise specified by the managing surgeon.
6. An operative report describing techniques, findings, and tissues removed or altered, the name of the primary surgeon and assistants, and pre-operative and post-operative diagnosis must be dictated immediately following surgery and signed by the surgeon.
7. A brief note as to the Operative findings and the nature of the surgery must be written in the progress notes at the time of surgery so that the patient does not return to the floor without this information on the chart.
8. An assistant is recommended in cases where a body cavity is entered. These can include, but are not limited to, major orthopedic, vascular, urologic and neurosurgical procedures. If there is a question as to

- whether an assistant is required, the Chair of the Department of Surgery, or their designee, shall make the final decision.
9. All tissues and foreign bodies removed at the time of surgery are to be sent to the Pathology Department, except specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, newborn foreskin, or portion of a rib removed only to enhance operative exposure.
  10. Preanesthesia evaluation by a physician, or when applicable, a qualified oral surgeon or CRNA, shall be documented in the medical records and shall include pertinent information relative to the choice of anesthesia, the surgical or dental procedure anticipated, the patient's previous drug history, other anesthetic experiences and potential anesthetic problems.
  11. The decision to discharge a patient from any postanesthesia care unit shall be made only by a physician or, when applicable, a qualified oral surgeon.
  12. The Medical Staff may develop discharge criteria provided they are specific, comprehensive, and approved by the Medical Staff to assure the same standard of care for all patients. When discharge criteria are developed, Medical Staff shall routinely review the practice to assure compliance with the criteria.
  13. A postanesthesia medical record entry shall be made by the physician or when applicable, a qualified oral surgeon or CRNA, in the post-operative period. A note shall describe the presence or absence of anesthesia related complications. The note must specify the date and the time it was written.
  14. Rules governing the conduct of the operating and recovery room shall be developed and monitored by an appropriate committee of the Medical Staff as determined by the Medical Executive Committee.
  15. Spine surgeries to be done as outpatient only: 1) cervical – bloodless with only incision to the skin and 2) Microdiscectomy and Anterior Discectomy, Level I and II. Patients may be discharged per physician order or using the approved discharge criteria for same day surgery.

## VIII. SCOPE OF CARE AND SERVICE

- A. Medical/Surgical:  
The Medical staff includes approved physicians under the direction of the Department of Medicine and Department of Surgery.
- B. Radiology:  
Imaging services include radiologic procedures, angiography, special procedures, computed tomography, magnetic resonance imaging, ultrasonography and nuclear medicine. Services are tailored to meet the needs of inpatients, outpatients or emergency patients ranging in age from neonates to geriatrics.
- B. Anesthesia:  
Anesthesiologists provide scheduled and emergency anesthetic services in the hospital.

The Anesthesia/Pain Management Section is a recognized section of the Department of Surgery. It includes approved physicians under the direction of the Anesthesia/Pain Management Section, which reports to the Department of Surgery. Certified Registered Nurse Anesthetists are also included in this section.

The Anesthesia/Pain Management Section has a separate set of Rules and Regulations, which are attached and are made a part of the Department of Surgery rules and regulations.

Revisions Approved:

8/00;

12/00;

3/02;

6/03

01/11