

**DEPARTMENT OF SURGERY
DIVISION OF ORTHOPEDIC SURGERY**

RECORD OF CLINICAL PRIVILEGES REQUESTED AND GRANTED

1. **Name:** MARK WOLGIN

2. **Department/Division/Section of Staff Appointment:** Surgery/Orthopedic Surgery

3. **Subject to Consultation Requirements and Other Policies**

I understand that in exercising any clinical privileges granted. I am constrained by any relevant Hospital and Medical Staff policies requiring consultations for difficult diagnoses, conditions of extreme severity, and procedures/conditions which are beyond my area of training, specialization, and current competence and experience, by any Hospital policies concerning the types of patients for whom it does not have appropriate resources (facilities, equipment or personnel) to treat except on an emergency basis, and by such special policies as may from time to time be adopted.

4. **Emergency Situations**

I also understand:

- (a) That the following delineation applies in non-emergency situations;
- (b) That it is not necessary to request "emergency" clinical privileges;
- (c) That an emergency is deemed to exist whenever serious or permanent harm or aggravation of injury or disease is imminent, or the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger;
- (d) That in such emergency I am authorized and will be assisted, when better alternative sources of care are not reasonably available given the patient's condition, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by my license but regardless of Department/Section affiliation, Staff category or level of privileges; and,
- (e) That if I provide services to a patient in an emergency, I am obligated to utilize appropriate consultative assistance when available and to arrange, when it is my responsibility, for appropriate follow-up care.

5. ORTHOPEDIC SURGERY PRIVILEGES REQUESTED AND GRANTED

This section identifies two categories of orthopedic surgery privileges as defined below. Any additions or deletions to, or conditions or other limitations on the exercise of, privileges in either category must be specified in writing. The granting, reviewing and changing of clinical privileges are accomplished in accordance with the criteria and procedures specified in the Medical Staff Bylaws and applicable Department/Service/Section rules. Additional qualifications for orthopedic surgery privileges are: certification by, or current active participation in the examination process leading to certification by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery, or successful completion of an approved residency program in orthopedic surgery, or equivalent formal training and experience, and in all instances current demonstrated competence and continuing experience in the privileges requested, including with pediatric patients of all ages except insofar as pediatric patients of any age group are specifically identified as being excluded from practice and except insofar as hospital policy requires transfer of certain pediatric patients (e.g., NICU patients) requiring surgery.

Category I privileges are those within the general framework of orthopedic surgery. Category II privileges are those that are new to or advanced in orthopedic surgery and must be supported by evidence of formal supervised training or clinical experience of sufficient breadth and length with acceptable results.

6. CATEGORY I PRIVILEGES

REQUESTED		GRANTED	CATEGORY I PRIVILEGES
X		✓	Closed treatment of fractures and dislocations of the axial and peripheral skeleton. Axial skeleton refers to the various segments of the spinal column and the pelvis.
X		✓	Open treatment of fractures and dislocations of the axial and peripheral skeleton.
X		✓	Corrective and reconstructive surgery of the axial skeleton, specifically including posterior spine fusion.
X		✓	Amputation surgery, including immediate prosthetic fitting in the operating room.
X		✓	Arthroscopy and arthrocentesis.
X		✓	Management of infections and inflammations of bones, joints and tendon sheaths.
X		✓	Arthrodesis and osteotomy of the major peripheral joints, excluding total replacement of the joint.
X		✓	Management of major soft tissue and musculoskeletal trauma.
X		✓	General evaluation of patients and pre- and post-operative care associated with the procedure performed.
X		✓	Perform history and physical examination.
			Administering conscious sedating drugs per hospital-wide policy, including patient evaluation, pre-procedure preparation, monitoring, titration of sedative/analgesic agent, administration of reversal agents and recovery care. ■ You must complete the attached request form and provide documentation in order to be considered for this privilege.
			Central Line Placement - CVP Line (must complete online sterile technique course and submit attestation to medical staff office) ■

DEPARTMENT OF SURGERY/DIVISION OF ORTHOPEDIC SURGERY
 DELINEATION OF PRIVILEGES – CONT'D

7. CATEGORY II PRIVILEGES

REQUESTER		GRANTED	CATEGORY II PRIVILEGES
X		✓	Biopsy and excision of tumors involving bone and adjacent soft tissues.
		✓	Reconstruction of congenital musculoskeletal anomalies.
1. <input checked="" type="checkbox"/> 2. <input checked="" type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input checked="" type="checkbox"/> 6. <input type="checkbox"/>		1. <input checked="" type="checkbox"/> 2. <input checked="" type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input checked="" type="checkbox"/> 6. <input type="checkbox"/>	Major arthroplasties of peripheral joints, including total replacement of the major joints, with or without use of cement. 1. Knee joint 2. Hip joint 3. Digital joint 4. Elbow joint 5. Shoulder joint 6. Other (specify):
X		✓	Anterior spinal fusion in cervical, dorsal or lumbar areas.
X		✓	Disc surgery, cervical and lumbar.
X		✓	Balloon Kyphoplasty – <u>You must complete the attached request form and provide documentation in order to be considered for this privilege.</u>
		✓	Hemipelvectomy.
X		✓	Hand surgery (See attached separate listing for requesting and granting)
1. <input type="checkbox"/> 2. <input checked="" type="checkbox"/>		1. <input type="checkbox"/> 2. <input checked="" type="checkbox"/>	Scoliosis Surgery 1. Harrington Rod 2. Anterior fusions, including Dwyer instrumentation
		✓	Chemonucleolysis
X		✓	Arthroscopic Surgery
1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/>		1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/>	Growth Disturbances 1. Injuries involving growth plates with a high percentage of growth arrest. 2. Growth inequality 3. Epiphyseodesis 4. Stapling 5. Bone shortening procedures 6. Bone lengthening procedures

ATTACHMENT TO CLINICAL PRIVILEGES IN ORTHOPEDIC SURGERY

8. HAND SURGICAL PRIVILEGES REQUESTED AND GRANTED

REQUESTED		GRANTED	CATEGORY I PRIVILEGES HAND SURGICAL PRIVILEGES
X		✓	Lacerations
X		✓	Superficial infection (e.g., cellulitis, focal abscesses, paronychia)
X		✓	Digital Tip Injuries (split graft or open treatment)
X		✓	Simple Polydactyly
X		✓	Skin Grafts
X		✓	Amputations
X		✓	Trigger finger, DeQuervain's disease
X		✓	Carpal tunnel decompression
X		✓	Fracture carpal bones (open and closed reduction)
X		✓	Ganglion (palm or wrist; flexor sheath; etc.)
X		✓	Arthrodesis
X		✓	Flexor tendon repair (forearm)
X		✓	Bone graft pertaining to hand
			Insertion of silicone rod
			Tendon grafts
REQUESTED		GRANTED	CATEGORY II PRIVILEGES HAND SURGICAL PRIVILEGES
X		✓	Major infections (e.g. felon, flexor sheath space infections)
			Arthroplasty large and small joints - including implants
			Other congenital malformations
			Digital transposition, pollicization, ray resection
			Fasciectomy for Dupuytren's contracture
X		✓	Fasciotomy
			Complex tumors
			Major reconstruction (mallet Boutonniere, Swan neck, tenolysis)

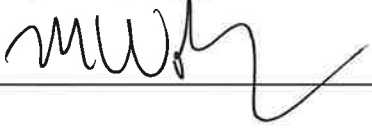
ATTACHMENT TO CLINICAL PRIVILEGES IN ORTHOPEDIC SURGERY – cont'd

REQUESTED		GRANTED	HAND SURGICAL PRIVILEGES – cont'd
			Tendon transfer
X		✓	Flexor tendon repair (wrist, palm, digits)
			Tendon reconstruction (free graft, staged)
X		✓	Extensor tendon repair
X		✓	Neurorrhaphy, neurolysis
			Nerve graft
			Rheumatoid reconstruction (soft tissue - synovectomy, tendons, etc.)
			Repair large vessels
			Microvascular repair small vessels
			Pedicle flaps
			Free tissue transfers (e.g., free flap, toe-to-hand)
X		✓	Excision of ganglion
X		✓	Osteotomy pertaining to the hand

ACKNOWLEDGMENT OF PRACTITIONER

I understand that:

- a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
- b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situations my actions are governed by the Medical Staff Bylaws.

Signed: 

Date: 8/25/23

CREDENTIALING CRITERIA FOR PRIVILEGES TO ADMINISTER CONSCIOUS SEDATION

Privileges will be granted to members of the Phoebe Putney Memorial Hospital Medical and Affiliate Staffs who have fulfilled credentials requirements for Conscious Sedation.

EXCLUSIONS: This policy DOES NOT:

- Include patients who require general anesthesia and have lost protective reflexes and are unable to maintain a patent airway independently (See Anesthesia Policies & Procedures);
- Include patients who require therapeutic pain management (See Pain Management Policy);
- Include patients who require sedation for maintenance on a ventilator;
- Include patients who require sedation to control seizures;
- Include patients that undergo monitored anesthesia care (MAC) given by anesthesia providers;
- Include pre-operative benzodiazepine for anxiolysis, OR when Oral benzodiazepine is the only medication (e.g., lorazepam dose <= 2 mg)

REQUIREMENTS:

PLEASE CHECK CRITERIA MET	CRITERIA
1.	Board certification/admissibility by the American Board of Anesthesiology, the American Board of Emergency Medicine, the American Board of Internal Medicine for Pulmonology, the American Board of Pediatrics in Neonatal/Perinatal Medicine; OR
2.	Documentation of recent graduation from an approved residency that included training in conscious sedation. A letter from the Chairman of the Residency Training Program confirming training, performance, and the number of cases performed must be provided; OR
3.	If the applicant has conscious sedation privileges at Phoebe Putney Hospital or another accredited health facility, he/she must provide evidence of current competency; OR
4.	Evidence of successful completion of education session related specifically to conscious sedation that includes: A. Guidelines/protocols of monitoring patients during conscious sedation; B. Knowledge of correct dosage and complications of drugs defined for conscious sedation use; C. Must have a clear understanding of the definition of conscious sedation; D. Pass a clinical competency test; E. Be ACLS, PALS or NRP Certified or demonstrate airway management competency through a proctoring program with Phoebe Anesthesiology Department.
5.	CRNA/PAA, serving in the hospital, providing conscious sedation under the direction of an anesthesiologist who is a member in good standing of the PPMH medical staff.
6.	APRNs and PAs serving in the hospital outside of the O.R. who meet the criteria under #4, providing conscious sedation under the direction of a physician who is a member in good standing of the PPMH medical staff.
Continued Privileges	To maintain these privileges must provide evidence of current clinical competency and documentation of appropriate outcomes at time of reappointment.

Practitioner Requesting _____ Date _____

Approved by MEC: 3/6/2001
 Approved by Board: 4/11/2001
 Revised & Approved by MEC: 1/2006
 Revised & Approved by MEC: 1/14/2006
 Revised & Approved by MEC: 9/1/2009

**CREREDENTIALING CRITERIA FOR PRIVILEGES
TO PERFORM BALLOON KYPHOPLASTY**

In order to be eligible to request clinical privileges for balloon kyphoplasty, an applicant must meet the following minimum threshold criteria:

REQUIREMENTS:

PLEASE CHECK CRITERIA MET	CRITERIA	
	1.	Be an MD or a DO
	2.	Have completed an ACGME/AOA accredited residency program in either orthopedic surgery, neurosurgery or radiology,
	3.	a) Have attended a didactic and hands-on course in vertebral augmentation with proctoring by a company representative and provide documentation of course attendance and completion, OR
		b) Provide documentation that he/she has satisfactorily performed a minimum of 10 balloon kyphoplasty procedures in the past 12 months either in a residency/fellowship program or private practice proctored by a physician privileged to perform this procedure, OR
		c) Verify training via satisfactory letter of reference from either the director of the applicant's training program and/or a letter of reference regarding competence from the Chair of Orthopedics, Neurosurgery or Radiology at the institution where the applicant most recently practiced and/or a satisfactory letter from the proctoring physician.
X	Continued Privileges	To maintain these privileges practitioners must be able to demonstrate that they have maintained competence by showing evidence that they have satisfactorily performed at least 5 balloon kyphoplasty procedures annually over the past two years (10 procedures during a two-year reappointment period).

Practitioner Requesting

mwolgin

MARK WOLGIN

Date

8/25/23