



Clinical Privileges Profile Radiation Oncology

Kettering Medical Center

Privileges are covered by an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience.

Applicant: Check off the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Clinical Service Chief: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

1. Note that privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.
2. This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR RADIATION ONCOLOGY

To be eligible to apply for core privileges in radiation oncology, the initial applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in radiation oncology.

AND

Current certification or active participation in the examination process with achievement of certification within six years leading to certification in therapeutic radiology or radiation oncology by the American Board of Radiology or the American Osteopathic Board of Radiology.

Required previous experience: Applicants for initial appointment must be able to demonstrate performance of at least 125 irradiation procedures, reflective of the scope of privileges requested, during the past 12 months or demonstrate successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months

Reappointment requirements: To be eligible to renew core privileges in radiation oncology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience (125 irradiation procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

CORE PRIVILEGES

RADIATION ONCOLOGY CORE PRIVILEGES

- Requested** Admit and provide comprehensive (multidisciplinary) evaluation and treatment planning for patients with cancer, related disorders, and therapeutic radiation for benign diseases, and consult on patients of all ages. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

SPECIAL NONCORE PRIVILEGES (SEE SPECIFIC CRITERIA)

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and maintenance of clinical competence.

BREAST BRACHYTHERAPY

Criteria: Successful completion of an accredited ACGME or AOA postgraduate training program in radiation oncology and completion of a formal course in regular breast brachytherapy and experience and training in the particular radiation therapy system to be used.

Required previous experience: Demonstrated current competence and evidence of the performance of at least 10 regular breast brachytherapy procedures or 10 radiation therapy system procedures in the past 12 months.

Maintenance of privilege: Demonstrated current competence and evidence of the performance of at least 10 regular breast brachytherapy procedures or 10 radiation therapy system procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes. Applicant must demonstrate training and experience with the specific radiation therapy system to be used.

- Requested**

GAMMA KNIFE

- Requested** (SEE Separate Clinical Privilege Profile)

ADMINISTRATION OF SEDATION AND ANALGESIA

- REQUESTED SEE HOSPITAL POLICY FOR MODERATE SEDATION**

CORE PROCEDURE LIST

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

To the applicant: If you wish to exclude any procedures, please strike through those procedures that you do not wish to request, initial, and date.

1. Administration of drugs and medicines related to radiation oncology and cancer supportive care
2. Administration of radiosensitizers, radioprotectors under appropriate circumstances
3. Brachytherapy both interstitial and intracavitary and unsealed radionuclide therapy, including HDR
4. Combined modality therapy (e.g., surgery, radiation therapy, chemotherapy, or immunotherapy used concurrently or in a timed sequence)
5. Computer assisted treatment simulation and planning (external beam therapy and radioactive implants)
6. Electron beam radiotherapy
7. Fractionated stereotactic radiotherapy
8. Immunotherapy
9. Intraoperative radiation therapy
10. Utilizes imaging studies as they pertain to neoplastic or benign conditions
11. Linear accelerator radiotherapy – photon & electron
12. Perform history and physical exam
13. Placement of catheters, IV's, IV contrast dye and radiopaque devices that pertain to treatment planning
14. Radiation prescription of doses, treatment volumes, field blocks, molds and other special devices for external beam therapy
15. Radiation therapy by external beam (photon and electron irradiation)
16. Radiation therapy contact therapy (SR, molds, etc.)
17. Radioactive isotope therapy: intraperitoneal, intracavitary, interstitial, intraluminal implantation, regional and systemic, and intravenous, radioactive antibody therapy
18. Stereotactic radiosurgery
19. Total body irradiation
20. Orders and utilizes X-ray, ultrasound, CT, MRI and PET, to assist in treatment planning

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at Hospital, and I understand that:

- a. In exercising any clinical privileges granted, I am constrained by 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 situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature: _____

Date: _____

CLINICAL SERVICE CHIEF'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

- Recommend all requested privileges.
- Recommend privileges with the following conditions/modifications:
- Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

Clinical Service Chief's Signature: _____ **Date:** _____

FOR MEDICAL STAFF OFFICE USE ONLY

Credentials Committee action **Date:** _____
Medical Executive Committee action **Date:** _____
Board of Directors action **Date:** _____

Adopted: November 11, 2010