Background

According to the American College of Physicians, pulmonary disease is the subspecialty of internal medicine concerned with diseases of the lungs, upper airways, thoracic cavity, and chest wall.

Pulmonary disease specialists also have expertise in malignant, inflammatory, and infectious diseases of the lung; pulmonary vascular disease and its effect on the cardiovascular system; and detection and prevention of lung disease due to occupational or environmental causes. Pulmonologists also may manage patients with respiratory failure and breathing problems resulting from a sleep disorder.

Pulmonologists typically treat patients for the following complex pulmonary problems, referring patients who require surgery to a general or thoracic surgeon:

➤ Asthma
➤ Emphysema
➤ Lung cancer
➤ Recurrent pneumonia
➤ Tuberculosis
➤ Complicated chest infections or chest injuries
➤ Pulmonary complications from AIDS
➤ Complications from respiratory diagnostic and therapeutic procedures
➤ Cystic fibrosis

Although pulmonary disease is a distinct subspecialty of internal medicine, it is related to critical care medicine because pulmonologists may work with patients who require mechanical ventilation. Consequently, there are two options for fellowship programs in this practice area: pulmonary disease training and combined pulmonary disease and critical care medicine training.

Following medical school, pulmonologists successfully complete an Accreditation Council for Graduate Medical Education (ACGME)– or an American Osteopathic Association (AOA)–accredited postgraduate training program in internal medicine, followed by a two-year training program in pulmonary disease. Combined pulmonary disease and critical care medicine training programs are three years in duration, with at least 18 months of clinical training (six months of pulmonary training, six months of critical care training, and six months of combined training).
The American Board of Medical Specialties (ABMS) recognizes pulmonary disease as a subspecialty of internal medicine. The American Board of Internal Medicine (ABIM) and the American Osteopathic Board of Internal Medicine (AOBIM) offer subspecialty certification in pulmonary disease and dual certification in pulmonary disease and critical care medicine. Physicians applying for dual certification in pulmonary disease and critical care medicine must be certified in pulmonary disease before they can sit for the critical care medicine exam. Successful completion of a combined pulmonary disease and critical care medicine fellowship program enables physicians to sit for both the pulmonary board exam and the certificate exam in critical care medicine.

**Involved specialties**

Pulmonologists, internists, critical care

**Positions of specialty boards**

**ABIM**

For subspecialty certification in pulmonary disease, physicians sit for the examination offered by the ABIM. The ABIM grants certificates in the subspecialty of pulmonary disease to physicians who have satisfied the following requirements:

➤ Certified in internal medicine by the ABIM
➤ Completed the requisite training
➤ Demonstrated clinical competence in the care of patients
➤ Met the licensure and procedural requirements
➤ Passed the subspecialty exam for that discipline

The ABIM requires 24 months of pulmonary disease training, with a minimum of 12 months of clinical training. Procedures that should be covered in the applicant’s training program include the following:

➤ Airway management, including endotracheal intubation
➤ Fiber-optic bronchoscopy and accompanying procedures
➤ Noninvasive and invasive ventilator management
➤ Thoracentesis
➤ Arterial puncture
➤ Placement of arterial, central venous, and pulmonary artery balloon flotation catheters
➤ Calibration and operation of hemodynamic recording systems
➤ Supervision of the technical aspects of pulmonary function testing
➤ Progressive exercise testing
➤ Insertion and management of chest tubes
➤ Moderate sedation

The ABIM strongly recommends that candidates be proficient in use of ultrasound to guide central line placement; however, it is not a procedural requirement.
The ABIM requires documentation that candidates for certification are competent in the following:
➤ Patient care, which includes medical interviewing, physical examination, and procedural skills
➤ Medical knowledge
➤ Practice-based learning and improvement
➤ Interpersonal and communication skills
➤ Professionalism
➤ Systems-based practice

The ABIM also offers dual certification in pulmonary disease and critical care medicine. Candidates seeking dual certification must complete a minimum of three years of accredited combined training, 18 months of which must be clinical training.

Only candidates certified in a subspecialty following at least two years of accredited fellowship training may take the critical care medicine examination after completing 12 months of accredited clinical critical care medicine fellowship training. Candidates certified in internal medicine must complete only 24 months of accredited critical care medicine fellowship training, including 12 months of clinical training, to qualify for the critical care medicine examination. Candidates who apply for dual certification in pulmonary disease and critical care medicine with three years of combined training must achieve certification in pulmonary disease before being eligible to apply to take the critical care medicine examination.

**AOBIM**

Physicians certified by the AOBIM in internal medicine may become certified in the subspecialty area of pulmonary disease. Candidates must also meet the following minimum requirements:
➤ Complete two years of AOA-approved training in pulmonary disease
➤ Demonstrate clinical competence in pulmonary disease
➤ Hold a valid license to practice medicine in jurisdiction
➤ Be a member, in good standing, of the AOA for at least two consecutive years
➤ If requested, demonstrate conformity to the standards set in the AOA Code of Ethics

The AOBIM offers dual certification in pulmonary disease and critical care medicine. Candidates seeking dual certification must complete a minimum of three years of accredited combined training: two years of training in pulmonary diseases, followed by one year of training in critical care medicine.
Positions of societies, academies, colleges, and associations

**ACCP**

The American College of Chest Physicians (ACCP) is a society of physicians, graduate degree holders (including but not limited to PhD, PharmD, DNSc, DMSc, or Dr Ph), and allied health professionals who specialize in promoting the prevention, diagnosis, and treatment of chest diseases. Applicants for ACCP membership must fulfill the following minimum criteria:

➤ Specialize in disciplines related to the function and diseases of the chest (including but not limited to pulmonary, critical care, sleep medicine, and thoracic surgery) and devote at least 50% of their professional time to this specialty

➤ Be certified by both an accredited primary medical or surgical board and an applicable subspecialty board

➤ Be sponsored by two ACCP members, preferably fellows, in their community

Physician applicants for ACCP membership must have completed their medical education; be board-certified in their primary specialty and have a license to practice medicine; express an interest in cardiopulmonary medicine or surgery, critical care, or related disciplines; and be engaged in clinical medicine, research, teaching, or administration. Unlike ACCP fellowship, training in a subspecialty is not required for ACCP membership status.

The ACCP does not publish guidelines for the delineation of clinical privileges in pulmonary disease. However, with regard to the performance of “advanced procedures,” the ACCP published *Interventional Pulmonary Procedures: Guidelines From the American College of Chest Physicians*.

According to the ACCP, the number and complexity of procedures performed in the chest increases annually. “Unfortunately,” the college states, “the training and expertise in interventional pulmonary procedures among pulmonary medicine specialists, critical care medicine specialists, and thoracic surgery is not uniform ... When learning new techniques, the old adage ‘see one, do one, teach one’ is no longer acceptable.”

The ACCP guidelines further state, “Despite the proliferation in the number and type of chest procedures currently performed, there are presently no guidelines that ensure that the basic skills and competency needed to provide these services have been acquired by the pulmonologist, critical care physician, or thoracic surgeon (dedicated operators).”

The guidelines address the following invasive procedures with regard to the necessary equipment and personnel, anesthesia and monitoring requirements, technique, indications and contraindications, risks, and training requirements:

➤ Flexible, rigid, and pediatric bronchoscopy

➤ Transbronchial needle aspiration
➤ Autofluorescence bronchoscopy
➤ Endobronchial ultrasound
➤ Laser therapy
➤ Endobronchial electrocautery and argon plasma coagulation
➤ Cryotherapy
➤ Brachytherapy
➤ Photodynamic therapy
➤ Airway stent placement
➤ Thoracic percutaneous needle aspiration
➤ Tube thoracostomy
➤ Medical thoracoscopy/pleuroscopy
➤ Percutaneous pleural biopsy
➤ Percutaneous dilatational tracheostomy
➤ Transtracheal oxygen therapy

The guidelines advise physicians who wish to learn how to perform an advanced chest procedure to take one of several educational approaches:
➤ Participate in one of the many intense short training programs (one to three days) available throughout the United States and abroad
➤ Participate in a more formal mini-sabbatical (one to six months)
➤ Enroll in a fellowship training program that offers an additional year of fellowship training in advanced interventional techniques similar to other procedure-intensive internal medicine subspecialties (e.g., cardiology and gastroenterology—both have adopted minimum requirements for competence in advanced procedures)
➤ Pursue “innovative approaches” (e.g., virtual reality–simulated bronchoscopy) to learn new techniques

ATS

The American Thoracic Society (ATS) is a professional and scientific society for respiratory, critical care, and sleep medicine physicians, nurses, allied health professionals, and scientists. Although the ATS does not publish general guidelines for the delineation of clinical privileges in pulmonary disease, the society does publish various evidence-based statements, training guidelines, and reports for physicians who treat patients with specific conditions (e.g., Curriculum and Competency Assessment Tools for Sleep Disorders in Pulmonary Fellowship Training Programs, Guidelines for the Management of Adults With Community-Acquired Pneumonia, and Standards for the Diagnosis and Management of Patients With COPD).

AACVPR

The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) exists to reduce morbidity, mortality, and disability from cardiovascular and pulmonary diseases through education, prevention, rehabilitation, research, and aggressive disease management. The AACVPR offers certification
in pulmonary rehabilitation and publishes the document \textit{Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals}. However, the AACVPR does not publish guidelines for the delineation of clinical privileges in pulmonary disease.

\textbf{ACGME}

The ACGME states in \textit{Program Requirements for Fellowship Education in Pulmonary Disease} that a subspecialty educational program in pulmonary disease must be 24 months in length with a minimum of 12 months devoted to clinical experiences. A minimum of nine months of training must be spent in non–critical care pulmonary disease rotations, and a minimum of three months of training must be spent in the medical ICU.

The ACGME further states that a subspecialty program in pulmonary disease must provide the fellow with clinical experience in the following:

\begin{itemize}
  \item Obstructive lung diseases, including asthma, bronchitis, emphysema, and bronchiectasis
  \item Pulmonary malignancy, primary and metastatic
  \item Pulmonary infections, including tuberculosis, fungal, and those in the immunocompromised host (e.g., HIV-related infections)
  \item Diffuse interstitial lung disease
  \item Pulmonary vascular disease, including primary and secondary pulmonary hypertension and the vasculitis and pulmonary hemorrhage syndromes
  \item Occupational and environmental lung diseases
  \item Iatrogenic respiratory diseases, including drug-induced disease
  \item Acute lung injury, including radiation, inhalation, and trauma
  \item Management of circulatory failure
  \item Pulmonary manifestations of systemic diseases, including collagen vascular disease and diseases that are primary in other organs
  \item Respiratory failure, including adult respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders
  \item Disorders of the pleura and the mediastinum
  \item Sleep disorders, including the recognition and differential diagnosis of common sleep symptoms, the effects of sleep on pulmonary diseases and treatments, the utility and interpretation of cardiopulmonary monitoring, critical review of polysomnographic reports, and management of sleep-disordered breathing
  \item Pulmonary embolism and pulmonary embolic disease
\end{itemize}

Further, fellows must have formal instruction and clinical experience in the prevention, evaluation, and management of both inpatients and outpatients with genetic and developmental disorders of the respiratory system, including cystic fibrosis, and in pulmonary rehabilitation. With regard to patient care, fellows
must demonstrate competence in promoting health, preventing disease, and diagnosis, care, and treatment of men and women of all ages, during health and all stages of illness.

With regard to technical and other skills, the ACGME states that fellows must have formal instruction, clinical experience, and demonstrated competence in the following:

- Airway management
- The use of a variety of positive pressure ventilatory modes, including initiation of:
  - Ventilatory support
  - Weaning and respiratory care techniques
  - Maintenance and withdrawal of mechanical ventilatory support
- The use of reservoir masks and continuous positive airway pressure (CPAP) masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry
- Flexible fiber-optic bronchoscopy procedures (a minimum of 100 such procedures)
- Management of pneumothorax (needle insertion and drainage system)
- Chest tubes and drainage systems
- Insertion of arterial, central venous, and pulmonary artery balloon flotation catheters
- Pulmonary function tests to assess respiratory mechanics and gas exchange, including spirometry, flow volume studies, lung volumes, diffusing capacity, arterial blood gas analysis, and exercise studies
- Diagnostic and therapeutic procedures, including thoracentesis, endotracheal intubation, and related procedures
- Operation of hemodynamic bedside monitoring systems
- Examination and interpretation of sputum, bronchopulmonary secretions, and pleural fluid
- Ultrasound-guided thoracentesis and placement of intravascular and intracavitary tubes and catheters

Formal instruction and clinical experience are also required for emergency cardioversion, inhalation challenge studies, thoracostomy tube insertion and drainage, and examination and interpretation of lung tissue for infectious agents, cytology, and histopathology.

In its Program Requirements for Fellowship Education in Pulmonary Disease and Critical Care Medicine, the ACGME states that a combined subspecialty educational program in pulmonary disease and critical care medicine must be three years in duration, with at least 18 months of clinical training (six months of pulmonary training, six months of critical care training, and six months of combined training), although 24 months of clinical training is recommended. The 18 months of clinical training must include:
At least nine months of meaningful patient care responsibility for inpatients and outpatients with a wide variety of pulmonary disease, with an emphasis on pulmonary physiology and its correlation with clinical disorders

At least nine months of clinical training in critical care medicine, of which:
- At least six months are devoted to the care of critically ill medical patients (i.e., medical ICU/cardiac ICU or equivalent).
- At least three months are devoted to the care of critically ill non-medical patients (i.e., surgical ICU, burn unit, transplant unit, neuro-intensive care, or equivalent). This experience should consist of at least one month of direct patient care activity, with the remainder being fulfilled with either consultative activities or with direct care of such patients.

In addition, fellows must have a continuity care clinic experience throughout the length of the training program. As a result, in programs with fewer than 24 months of required clinical experience, additional ambulatory experience (e.g., longitudinal experiences in cystic fibrosis, interstitial lung disease, etc.) of one half-day per week must be provided for fellows for six months. This ambulatory experience must not occur during the 18 months of clinical training. Further, fellows may be excused from their continuity care clinic experience while on critical care rotations. Regardless of the required clinical experience in the training program, the total required ICU experiences must not exceed 15 months in the three years of training.

AOA

The AOA states in Specific Requirements for Osteopathic Fellowship Training in Pulmonary Disease that a fellowship program in pulmonary disease must be 24 months in length. This includes a minimum of one half-day per week of outpatient experience to provide continuity of care, develop a defined panel of patients, and follow progress of treatment on a long-term basis.

The AOA further states that a program in pulmonary disease must provide the fellow with the following clinical experiences:
- Management of obstructive lung diseases, including asthma, bronchitis, emphysema, and bronchiectasis
- Pulmonary malignancy, primary and metastatic
- Pulmonary infections, including tuberculosis, fungal, and those in the immunocompromised host
- Diffuse interstitial lung disease
- Pulmonary vascular disease, including primary and secondary pulmonary hypertension and the vasculitis and pulmonary hemorrhage syndromes
- Occupational and environmental lung diseases
Pulmonary disease

➤ Iatrogenic respiratory diseases, including drug-induced disease
➤ Acute lung injury, including radiation, inhalation, and trauma
➤ Pulmonary manifestations of systemic diseases, including collagen vascular disease and diseases that are primary in other organs
➤ Respiratory failure, including adult respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders
➤ Disorders of the pleura and the mediastinum
➤ Sleep disorders
➤ Genetic and developmental disorders of the respiratory system

With regard to technical and other skills, the AOA states that fellows must demonstrate competence in performing the following:
➤ Pulmonary function tests to assess respiratory mechanics, gas exchange, and respiratory drive, including spirometry, flow volume studies, lung volumes, diffusing capacity, distribution of ventilation, airways resistance, lung compliance, arterial blood gas analysis, and exercise studies
➤ Calibration and operation of hemodynamic recording systems
➤ Thoracentesis, flexible fiber-optic bronchoscopy and related procedures, endotracheal intubation, percutaneous arterial puncture and cannulation, central venous catheterization, and pulmonary artery balloon catheterization
➤ Ventilatory support including pressure-cycled, volume-cycled, time-cycled, and flow-cycled mechanical ventilation
➤ Weaning, long-term ventilator care, pulmonary rehabilitation, and respiratory care
➤ Management of pneumothorax (needle insertion and drainage system) and chest tube insertion
➤ Examination and interpretation of sputum, bronchopulmonary secretions, pleural fluid and lung tissue for infectious agents, cytology, and histopathology

Other skills include the ability to examine and interpret imaging procedures including chest roentgenograms, CAT scans, PET scans, radionuclide scans, and pulmonary angiograms, sleep studies, and inhalation challenge studies. Competence in monitoring and supervising critical care units, pulmonary function laboratories, respiratory physical therapy and rehabilitation services, and respiratory care techniques and services are also required.

Further, fellows must have formal instruction and clinical experience in the consultation, diagnosis, and management of both inpatients and outpatients with a wide variety of pulmonary diseases. Fellows are required to have a minimum of one half-day per week of outpatient experience to provide continuity of care, develop a defined panel of patients, and follow progress of treatment on a long-term basis.
Positions of accreditation bodies

**CMS**

CMS has no formal position concerning the delineation of privileges for pulmonary disease. However, the CMS *Conditions of Participation (CoP)* define a requirement for a criteria-based privileging process in §482.22(c)(6), stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.
The Joint Commission

The Joint Commission has no formal position concerning the delineation of privileges for pulmonary disease. However, in its Comprehensive Accreditation Manual for Hospitals, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for MS.06.01.05 include several requirements as follows:

- The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
- Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
- Consistent application of criteria
- A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
- Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
➤ A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
➤ A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
➤ A decision (action) on the completed application for privileges occurs within the time period specified in the organization’s medical staff bylaws
➤ Information regarding any changes to practitioners’ clinical privileges are updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.
**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for pulmonary disease. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff's review of an individual practitioner's qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

Det Norske Veritas (DNV) has no formal position concerning the delineation of privileges for pulmonary disease. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”
The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

CRC draft criteria

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding pulmonary disease. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

Minimum threshold criteria for requesting core privileges in pulmonary disease

Basic education: MD or DO
Minimal formal training: Successful completion of an ACGME- or AOA-accredited fellowship in pulmonary disease, and/or current certification or
active participation in the examination process (with achievement of certification within [n] years) leading to certification in pulmonary medicine by the ABIM or completion of a certificate of special qualifications in pulmonary diseases by the AOBIM.

Required current experience: Inpatient or consultative pulmonary medicine services, reflective of the scope of privileges requested, to at least 50 patients during the past 12 months, or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

References
If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges in pulmonary disease
Core privileges for pulmonary medicine include the ability to admit, evaluate, diagnose, treat, and provide consultation to patients of all ages presenting with conditions, disorders, and diseases of the lungs and airways. Physicians may provide care to patients in the intensive care setting in conformance with unit policies; they may also assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include but are not limited to the following procedures:
➤ Performance of history and physical exam
➤ Airway management
➤ CPAP
➤ Diagnostic and therapeutic procedures, including thoracentesis, endotracheal intubation, and related procedures
➤ Emergency cardioversion
➤ Examination and interpretation of sputum, bronchopulmonary secretions, pleural fluid, and lung tissue
➤ Flexible fiber-optic bronchoscopy procedures
➤ Inhalation challenge studies
➤ Insertion of arterial, central venous, and pulmonary artery balloon flotation catheters
➤ Management of pneumothorax (needle insertion and drainage system)
➤ Operation of hemodynamic bedside monitoring systems
➤ Pulmonary function tests to assess respiratory mechanics and gas exchange, including spirometry, flow volume studies, lung volumes, diffusing capacity, arterial blood gas analysis, and exercise studies
➤ Thoracostomy tube insertion and drainage, including chest tubes
➤ Use of reservoir masks and CPAP masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry
➤ Use of a variety of positive pressure ventilatory modes, including:
  – Ventilatory support, including bilevel positive airway pressure
  – Weaning and respiratory care techniques
  – Maintenance and withdrawal of mechanical ventilatory support

Special noncore privileges in pulmonary disease

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. Noncore privileges include:
➤ Diagnostic thoracoscopy, including biopsy
➤ Endobronchial ultrasound
➤ Administration of sedation and analgesia

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.

Applicants for pulmonary disease must be able to demonstrate current competence and an adequate volume of experience (inpatient or consultative services for at least 100 patients) 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 physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to pulmonary medicine should be required.

For more information

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Chicago, IL 60610-4322
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Fax: 312/755-7498
Website: www.acgme.org
American Association of Cardiovascular and Pulmonary Rehabilitation
401 North Michigan Avenue, Suite 2200
Chicago, IL 60611
Website: www.aacvpr.org

American Board of Internal Medicine
510 Walnut Street, Suite 1700
Philadelphia, PA 19106-3699
Telephone: 215/466-3500 or 800/441-2246
Fax: 215/446-3633
Website: www.abim.org

American College of Chest Physicians
3300 Dundee Road
Northbrook, IL 60062-2348
Telephone: 847/498-1400 or 800/343-2227
Fax: 847/498-5460
Website: www.chestnet.org

American College of Osteopathic Internists
3 Bethesda Metro Center, Suite 508
Bethesda, MD 20814
Telephone: 301/656-8877
Fax: 301/656-7133
Website: www.acoi.org

American College of Physicians
190 North Independence Mall West
Philadelphia, PA 19106
Telephone: 215/351-2600
Website: www.acponline.org

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
Telephone: 312/202-8000
Fax: 312/202-8200
Website: www.osteopathic.org

American Thoracic Society
61 Broadway
New York, NY 10006-2755
Telephone: 212/315-8600
Fax: 212/315-6498
Website: www.thoracic.org
Pulmonary disease

Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Telephone: 877/267-2323
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