Background

Thoracic surgery is the medical specialty that involves the operative, perioperative, and critical care of patients with pathologic conditions within the chest. This includes surgical care of coronary artery disease; diseases of the trachea, lung, esophagus, and chest wall; abnormalities of the great vessels and heart valves; congenital anomalies of the chest and heart; tumors of the mediastinum; diseases of the diaphragm; and management of chest injuries.

According to the American Board of Medical Specialties, thoracic surgeons have the knowledge, experience, and technical skills to accurately diagnose, safely operate upon, and effectively manage patients with thoracic diseases of the chest. This requires knowledge of cardiorespiratory physiology and oncology, as well as capability in the use of heart assist devices, management of abnormal heart rhythms and drainage of the chest cavity, respiratory support systems, endoscopy, and invasive and noninvasive diagnostic techniques.

Following medical school, physicians must complete a training program in general surgery prior to entering a residency in thoracic surgery, during which they acquire the necessary knowledge, judgment, and technical skills in the specialty. As there are several different training paths for certification in thoracic surgery, the length of the residency can vary, but all programs require a minimum of two years of training in thoracic surgery.

After completing residency training, thoracic surgeons are eligible to obtain certification from the American Board of Thoracic Surgeons (ABTS). Some physicians complete additional subspecialty training in congenital cardiac surgery. Thoracic surgeons trained in American Osteopathic Association (AOA)—accredited residencies may obtain certification in cardiothoracic surgery from the American Osteopathic Board of Surgery (AOBS).

Related white papers:
➤ Cardiovascular (cardiac) surgery—Practice area 136

Involved specialties

Thoracic surgeons
Positions of specialty boards

**ABTS**

There are several training pathways available to candidates seeking certification by the ABTS:

- Successful completion of a residency in general surgery approved by the Accreditation Council for Graduate Medical Education (ACGME), followed by successful completion of an ACGME-approved thoracic surgery residency. Successful completion of a 4/3 general surgery/thoracic surgery joint training program approved by the ACGME, in which candidates complete four years of general surgery followed by three years of thoracic surgery, fulfills this requirement.

- Successful completion of a full residency in general surgery or cardiac surgery approved by the Royal College of Physicians and Surgeons of Canada, followed by the successful completion of an ACGME-approved thoracic surgery residency.

- Successful completion of a six-year integrated thoracic surgery residency that follows the guidelines established by the Thoracic Surgery Directors Association (TSDA) and approved by the ACGME Thoracic Surgery Resident Review Committee (TS-RRC).

- Successful completion of an ACGME-approved vascular surgery residency that can lead to primary certification in vascular surgery, followed by the successful completion of an ACGME-approved thoracic surgery residency.

Regardless of which pathway candidates choose, all candidates must meet the following requirements to obtain certification in thoracic surgery:

- Hold ethical standing in the profession and a moral status in the community that are acceptable to the ABTS

- Achieve satisfactory performance on the ABTS examinations

- Maintain and provide documentary evidence of a currently registered full, valid, and unrestricted license to practice medicine granted by a state or other United States jurisdiction

- Complete a minimum of 24 months of residency training in a thoracic and cardiovascular surgery program accredited by the TS-RRC, which must include 12 months of continuous senior responsibility

Residents may choose to follow either a cardiothoracic or a general thoracic training pathway. Residents who began their thoracic surgery training between July 1, 2007, and June 30, 2012, and are pursuing the cardiothoracic pathway should complete 255 major surgical procedures in the following areas:

- Congenital heart disease: 20
  - As primary: 10
  - As first assistant: 10

- Adult cardiac: 150
  - Acquired valvular heart: 50
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- Myocardial revascularization: 80
- Reoperation: 15*
- Aorta: 5
- Other: 15
➤ Lung, pleura, chest wall: 50
  - Pneumonectomy, lobectomy, segmentectomy: 30
  - Other: 20
➤ Mediastinum (resection): 5
➤ Esophageal: 15
  - Resection: 10
  - Other: 5
➤ Video-assisted thoracoscopic surgery (VATS): 15

Residents pursuing the cardiothoracic pathway should also meet the following procedure requirements:
➤ Endoscopy: 40
  - Bronchoscopy: 20
  - Esophagoscopy: 10
  - Mediastinoscopy: 10
➤ Consultation experience: 100
  - New patient: 50
  - Follow-up: 50

For residents pursuing the general thoracic pathway who began their training between July 1, 2007, and June 30, 2012, the 255 major surgical procedures should be broken down as follows:
➤ Congenital heart disease: 10
  - All cases can be as first assistant
➤ Adult cardiac: 75
  - Acquired valvular heart: 20
  - Myocardial revascularization: 40
  - Reoperation: 5*
  - Other: 15
➤ Lung, pleura, chest wall: 100
  - Pneumonectomy, lobectomy, segmentectomy: 50
  - Other: 50
➤ Mediastinum (resection): 10
➤ Esophageal: 30
  - Resection: 20
  - Benign esophageal disease: 5
  - Other: 5
➤ VATS: 30

Residents pursuing the general thoracic pathway must also meet the following procedure requirements:
Endoscopy: 90
  - Bronchoscopy: 40
  - Esophagoscopy: 25
  - Mediastinoscopy: 25

Consultation experience: 100
  - New patient: 50
  - Follow-up: 50

* According to the procedure requirements, reoperation procedures can be counted twice for any adult cardiac procedure. For example, a redo coronary artery bypass surgery may be counted as both a myocardial revascularization and a reoperation.

In 2012, the ABTS released updated case requirements for residents who begin their thoracic surgery training on or after July 1, 2012. Residents pursuing the cardiothoracic pathway should complete 302 major operative procedures, broken down as follows:

➤ Congenital heart disease: 20
  - As primary: 10
  - As first assistant: 10

➤ Adult cardiac: 189
  - Acquired valvular heart: 50
  - Myocardial revascularization: 80
  - Redo sternotomy: 15*
  - Interventional skills or procedures: 20
  - Conduit dissection and preparation: 10
  - Aortic procedures: 10
  - Arrhythmia surgery: 5
  - Cardiopulmonary bypass setup and pump run with perfusionist: 4
  - Circulatory assist/cardiac transplant: 10

➤ General thoracic: 93
  - Lung: 60
  - Pleura: 10
  - Chest wall and diaphragm: 3
  - Mediastinum: 5
  - Esophagus: 15

Residents pursuing the cardiothoracic pathway should also meet the following minor procedure requirements and additional requirements:

➤ Upper gastrointestinal (UGI) endoscopy: 10
➤ Bronchoscopy: 30
➤ Mediastinal assessment: 20
  - Mediastinoscopy: 10
  - Endobronchial ultrasound (EBUS)/fine-needle aspiration (FNA): 5
  - Chamberlain or mediastinal node dissection: 5
Multidisciplinary patient management conferences: 20
Cardiothoracic critical care case management experience: 75
Simulation: 20 hours
Consultation experience: 100
  – New patient: 50
  – Follow-up: 50

For residents pursuing the general thoracic pathway, 285 major surgical procedures should be broken down as follows:

➤ Congenital heart disease: 10
  – May be either primary or first assistant

➤ Adult cardiac: 104
  – Acquired valvular heart: 25
  – Myocardial revascularization: 40
  – Redo sternotomy: 5
  – Interventional skills or procedures: 20
  – Conduit dissection and preparation: 5
  – Aortic procedures: 5
  – Cardiopulmonary bypass setup and pump run with perfusionist: 4
  – Circulatory assist/cardiac transplant: 5

➤ General thoracic: 171
  – Lung: 100
  – Pleura: 20
  – Chest wall and diaphragm: 6
  – Mediastinum: 10
  – Tracheobronchial-airway surgery: 5
  – Esophagus: 30

Residents who start their training on or after July 1, 2012, and are pursuing the general thoracic pathway must also meet the following procedure requirements:

➤ UGI endoscopy: 25
➤ Bronchoscopy: 40
➤ Mediastinal assessment: 30
  – Mediastinoscopy: 15
  – EBUS/FNA: 10
  – Chamberlain or mediastinal node dissection: 5

➤ Multidisciplinary patient management conferences: 20
➤ Cardiothoracic critical care case management experience: 75
➤ Simulation: 20 hours
➤ Consultation experience: 100
  – New patient: 50
  – Follow-up: 50

* According to the procedure requirements, reoperation procedures can be counted twice for any adult cardiac procedure. For example, a redo coronary
artery bypass surgery may be counted as both a myocardial revascularization and a reoperation.

**AOBS**

The AOBS grants board certification in cardiothoracic surgery. In order to become board-certified by the AOBS, candidates must meet the following requirements:
- Graduate from an AOA-accredited college of osteopathic medicine
- Maintain and provide documentary evidence of an unrestricted license to practice in the state or military jurisdiction where practice is conducted
- Conform to the standards set forth in the Code of Ethics of the AOA
- Be a member in good standing of the AOA
- Satisfactory completion of an AOA-approved first postdoctoral year of training (OGME-1)
- Complete four years of training in general surgery followed by two years of training in cardiothoracic surgery
- Pass the written and oral examinations in general surgery
- Renew certification every 10 years

**Positions of societies, academies, colleges, and associations**

**STS**

The Society of Thoracic Surgeons (STS) is a nonprofit organization representing cardiothoracic surgeons, researchers, and allied health professionals. The STS offers membership to board-certified surgeons, residents, and nonphysicians working in the field of thoracic surgery.

The STS does not publish guidelines or position statements regarding the training, credentialing, or privileging of thoracic surgeons. However, the STS does publish Clinical Practice Guidelines on topics relevant to the diagnosis, management, or prevention of diseases or conditions within the field of thoracic surgery.

**AATS**

The American Association for Thoracic Surgery (AATS) is a professional organization for cardiothoracic surgeons with a focus on research and education. According to the AATS Code of Ethics, members of the AATS have a responsibility for lifelong learning, which includes active involvement in continuing medical education activities to ensure the continual development of skills, training, and expertise. Members should also maintain professional qualifications through continuous study consistent with evidence-based scientific practice.

The AATS acknowledges three training pathways in cardiothoracic surgery:
1. Traditional training pathway: Medical students complete a five-year general surgery residency followed by two to three years of clinical training in cardiothoracic surgery. Upon successful completion of training, residents may apply for certification by both the American Board of Surgery (ABS) and the ABTS.

2. Fast-track pathway: Certain general surgery residency programs offer a fast-track pathway in which residents complete four years of general surgery training followed by three years of cardiothoracic surgery.

3. Integrated pathway: This pathway requires direct application to an integrated cardiothoracic surgery residency program, which allows for more focused cardiothoracic training as well as training in related fields, such as interventional radiology, interventional cardiology, endovascular surgery, oncology, and pulmonary disease. Residents who successfully complete training are eligible for certification by the ABTS but not by the ABS.

AATS does not publish specific guidelines regarding credentialing or privileging of thoracic surgeons, or competency requirements.

**TSDA**

TSDA is a membership organization for cardiothoracic surgery residency program directors. The ABTS recognizes a six-year integrated training program modeled on the TSDA’s recommendations as one of the pathways through which residents may seek certification.

The TSDA’s website lists a comprehensive requisite thoracic surgery curriculum, which requires residents to study treatment and procedures relating to the following areas:

- Chest wall
- Lungs and pleura
- Trachea and bronchii
- Mediastinum and pericardium
- Diaphragm
- Esophagus
- Congenital heart disease
- Acquired heart disease
- Thoracic trauma
- Transplantation
- Extracorporeal bypass and coagulation
- Minor procedures, such as
  - Bronchoscopy
  - Esophagoscopy
  - Permanent pacemakers
  - Tube thoracostomy
  - Central valve lines and arterial lines
- Thoracic surgery and research
- Nonclinical elements of thoracic surgical practice
Geriatrics

The TSDA does not publish the specific number of procedures required for competency. However, the TSDA publishes a Manual for Creating a Comprehensive Six-Year Integrated Curriculum in Cardiothoracic Surgery, which compiles articles and information to aid program directors in designing and implementing residency programs in cardiothoracic surgery.

ACGME

The ACGME publishes Program Requirements for Graduate Medical Education in Thoracic Surgery. According to the guidelines, fellows must successfully complete a surgery residency program accredited by the ACGME prior to pursuing a two-year thoracic surgery program. Alternatively, graduates may choose to complete a seven-year joint surgery/thoracic surgery program accredited by the ACGME or a six-year integrated program accredited by the Liaison Committee of Medical Education that encompasses core surgical education and clinical thoracic surgery education.

At the completion of training, residents should be able to demonstrate competency in developing and executing patient care plans, demonstrating technical abilities, using information technology, and evaluating diagnostic studies. Residents should also:

➤ Provide preoperative management, including the selection and timing of operative intervention and the selection of appropriate operative procedures
➤ Provide postoperative management of thoracic and cardiovascular patients
➤ Provide critical care of patients with thoracic and cardiovascular surgical disorders, including trauma patients, regardless of whether operative intervention is required
➤ Correlate the pathologic and diagnostic aspects of cardiothoracic procedures (e.g., bronchoscopy and esophagoscopy)
➤ Interpret appropriate imaging studies (e.g., ultrasound, CT, roentgenographic, radionuclide, cardiac catheterization, pulmonary function, and esophageal function studies)
➤ Demonstrate knowledge in the use of cardiac and respiratory support devices

With regard to operative experience, residents should have a minimum operative experience that must include:

➤ A minimum of 125 annual major cases
➤ An adequate volume of operative experience, distribution of categories, and complexity of procedures to ensure a balanced and equivalent clinical education
➤ Categories of procedures that must include but are not limited to:
  − Lungs, pleura, and chest wall
  − Esophagus, mediastinum, and diaphragm
  − Thoracic aorta and great vessels
  − Congenital heart anomalies
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- Valvular heart diseases
- Myocardial revascularization

➤ Additional educational experiences, including:
  - Cardiac pacemaker implantation
  - Mediastinoscopy
  - Pleuroscopy
  - Flexible and rigid esophagoscopy and bronchoscopy
  - Endoscopic ultrasound
  - Endoscopic approaches to thoracic and esophageal diseases
  - Multidisciplinary approaches to the treatment of thoracic malignancy
  - Endovascular stents

Residents must have documented operative experience showing they participated in the diagnosis, preoperative planning, and selection of the operation for the patient, as well as documentation showing they performed those technical manipulations that constituted the essential parts of the patient’s operation and were substantially involved in postoperative care.

Residents should also have assignments to nonsurgical areas, such as cardiac catheterization and esophageal or pulmonary function, for a total of no more than three months during the program. This experience may not occur in the chief year. During the chief year, which should be spent in the sponsoring institute or integrated program sites, residents should assume senior responsibility for care of patients with thoracic and cardiovascular disease.

AOA

The AOA publishes Basic Standards for Residency Training in Surgery and Surgical Subspecialties (effective July 2011). The guidelines state that cardiothoracic residency programs should be two years in length, following the successful completion of an AOA-approved general surgery resident program that includes an OGME-1R year. Clinical experience may be achieved by formal affiliation with other institutions, but this may not exceed six months outside the primary training institution. The final 12 months of the program should be spent as a chief resident in approved institutions, under supervision, demonstrating advanced-level responsibilities for complete cardiothoracic surgical patient management.

These standards indicate that residents should demonstrate the following competencies. With regards to cognitive skills, residents should be able to:

➤ Correlate the pathologic and diagnostic aspects applicable to cardiothoracic surgery with clinical experiences in a progressive manner consistent with the cardiothoracic curriculum

➤ Develop critical thinking skills that result in making decisions for patient management

➤ Understand the relevance of, and interpret, research related to the practice of
cardiothoracic surgery
➤ Read, interpret, and participate in clinical and or basic science research

Residents should also demonstrate the following psychomotor and technical skills:
➤ Osteopathic principles, diagnoses, and therapies in the care of cardiothoracic patients
➤ Proficiency with the necessary technical skills required for the practice of cardiothoracic surgery
➤ The ability to provide progressive patient management responsibilities based upon knowledge of the basic and clinical sciences

With regards to communication skills, residents should be able to:
➤ Demonstrate the ability to collaborate with colleagues and allied healthcare professionals
➤ Educate patients and their families concerning healthcare needs
➤ Demonstrate the ability to teach medical students, interns, other residents, and allied healthcare staff within the context of residency education

In the area of practice management, residents should:
➤ Demonstrate leadership and management skills
➤ Provide cost-effective care to patients

With regards to professional attitudes and abilities, residents should be able to:
➤ Demonstrate a broad understanding of the role of cardiothoracic surgery as it relates to other medical disciplines
➤ Appreciate the value of lifelong learning in medical education and as related to a professional career in the field
➤ Demonstrate the ability to provide sound ethical and legal judgments
➤ Participate in continuing education to promote personal and professional growth
➤ Participate in community and professional organizations
➤ Apply the principles of evidence-based medicine to their professional practice

According to the guidelines, the cardiothoracic surgery curriculum must include the following learning experiences:
➤ Clinical learning experience in the preoperative, intraoperative, and postoperative care of patients with diseases of the heart and great vessels; lung, pleura, and trachea; and esophagus, mediastinum, diaphragm, and chest wall
➤ Additional experiences that should include:
  – Cardiopulmonary bypass physiology and mechanics
  – Pulmonary function examination
  – Noninvasive peripheral vascular examination
  – Chest x-ray, MRI and CT scan, and positron emission tomography scan interpretation
  – Cardiac catheterization interpretation
  – Cardiothoracic critical care management to include ventilator management
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- Fluid and electrolyte management
- Clinical hematology, coagulation, and blood component replacement therapy
- Pharmacological and mechanical-assisted management of hemodynamic instability and support
- Cancer chemotherapy and radiation therapy

➤ Electives in organ transplantation and mechanical cardiac assist devices (highly desirable)

The program must provide each resident with a sufficient scope, volume, and variety of clinical experience in cardiothoracic surgery. The standards required of individuals for successful completion of a program in cardiothoracic surgery and to qualify for entrance into the certification process by the AOBS must be through one of two primary pathways: a cardiothoracic surgery pathway or a general thoracic surgery pathway. At the completion of the program, each resident must document participation in 255 major surgical procedures, performed by the resident as surgeon under supervision. Residents pursuing the cardiothoracic pathway should meet the following numbers of case requirements:

➤ Congenital heart disease: 20
  - As primary: 10
  - As first assistant: 10

➤ Adult cardiac: 150
  - Acquired valvular heart: 50
  - Myocardial revascularization: 80
  - Reoperation: 15*
  - Aorta: 5
  - Other: 15

➤ Lung, pleura, chest wall: 50
  - Pneumonectomy, lobectomy, segmentectomy: 30
  - Other: 20

➤ Mediastinum (resection): 5

➤ Esophageal: 15
  - Resection: 10
  - Other: 5

➤ Video-assisted thoracoscopic surgery (VATS): 15

Residents pursuing the cardiothoracic pathway should also meet the following procedure requirements:

➤ Endoscopy: 40
  - Bronchoscopy: 20
  - Esophagoscopy: 10
  - Mediastinoscopy: 10

➤ Consultation experience: 100
  - New patient: 50
  - Follow-up: 50
For residents pursuing the general thoracic pathway, the 255 major surgical procedures should be broken down as follows:

- **Congenital heart disease**: 10
  - All cases can be as first assistant
- **Adult cardiac**: 75
  - Acquired valvular heart: 20
  - Myocardial revascularization: 40
  - Reoperation: 5*
  - Other: 15
- **Lung, pleura, chest wall**: 100
  - Pneumonectomy, lobectomy, segmentectomy: 50
  - Other: 50
- **Mediastinum (resection)**: 10
- **Esophageal**: 30
  - Resection: 20
  - Benign esophageal disease: 5
  - Other: 5
- **VATS**: 30

Residents pursuing the general thoracic pathway must also meet the following procedure requirements:

- **Endoscopy**: 90
  - Bronchoscopy: 40
  - Esophagoscopy: 25
  - Mediastinoscopy: 25
- **Consultation experience**: 100
  - New patient: 50
  - Follow-up: 50

* According to the procedure requirements, reoperation procedures can be counted twice for any adult cardiac procedure. For example, a redo coronary artery bypass surgery may be counted as both a myocardial revascularization and a reoperation.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for thoracic surgery. 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 thoracic surgery. 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 standard 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 that occurs within the time period specified in the organization’s medical staff bylaws

Information regarding any changes to practitioners’ clinical privileges, 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 thoracic surgery. 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 establishes 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**

DNV has no formal position concerning the delineation of privileges for thoracic surgery. 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 this practice area. 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 privileges in thoracic surgery**

**Basic education:** MD or DO

**Minimal formal training:** Applicants must be able to demonstrate successful completion of an ACGME- or AOA-accredited training program in thoracic surgery and/or demonstrate current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in thoracic surgery by the ABTS or the AOBS (cardio-thoracic surgery).

**Required current experience:** Applicants must be able to demonstrate that they have performed at least 125 thoracic surgical procedures, reflective of the scope of privileges requested, in the past 12 months or successfully completed 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 thoracic surgery

Core privileges for thoracic surgery include the ability to admit, evaluate, diagnose, and provide operative, perioperative, and critical care to patients of all ages with pathological conditions within the chest. This includes surgical care of coronary artery disease; cancers of the lung, esophagus, and chest wall; abnormalities of the trachea; abnormalities of the great vessels and heart valves; congenital anomalies of the chest; tumors of the mediastinum; and diseases of the diaphragm. Practitioners may provide care to patients in the intensive care setting in conformance with unit policies. Privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call service. The core privileges in this specialty include the procedures on the following procedure list and such other procedures that are extensions of the same techniques and skills:

- Performance of history and physical exam
- Cervical, thoracic, or dorsal sympathectomy
- Correction of diaphragmatic hernias, both congenital or acquired, and anti-reflux procedures
- Decortication or pleurectomy procedures
- Diagnostic procedures, including cervical and mediastinal exploration, parasternal exploration, and mediastinoscopy
- Endoscopic procedures, including bronchoscopy, esophagoscopy, and mediastinoscopy
- Implantation of cardioverter defibrillator
- Lymph node and superficial biopsy procedures
- Management of chest and neck trauma
- Operations for achalasia and for promotion of esophageal drainage
- Pericardiocentesis, pericardial drainage procedures, and pericardiectomy
- Procedures upon the chest wall, pleura, and lungs, including wedge resections, segmentectomy, lobectomy, and pneumonectomy
- Resection, reconstruction, or repair of the trachea and bronchi
- Resection, reconstruction, repair, or biopsy of the lung and its parts
- Surgery on the esophagus, mediastinum, and diaphragm, including surgery for diverticulum, as well as perforation, resections, transhiatal esophagectomy, surgery for benign esophageal disease, and surgery on mediastinum for removal of benign or malignant tumors
- Thoracentesis
- Thoracoscopy
- Thoracotomy for trauma, hemorrhage, rib biopsy, drainage of empyema, or removal of foreign body
- Tracheostomy
- Tube thoracostomy
- VATS
**Special noncore privileges in thoracic surgery**

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:

- Use of laser
- Use of robotic-assisted system
- Single-lung, double-lung, and heart transplantations (excluding that for infants and young children)
- Endovascular repair of thoracic aortic aneurysms and abdominal aortic aneurysms
- Administration of sedation and analgesia

**Reappointment**

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

To be eligible to renew privileges in thoracic surgery, the applicant must have current demonstrated competence and an adequate volume of experience (250 thoracic surgical 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 physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to thoracic surgery should be required.

**For more information**

**Accreditation Council for Graduate Medical Education**
515 North State Street, Suite 2000
Chicago, IL 60654
Telephone: 312-755-5000
Fax: 312-755-7498
Website: [www.acgme.org](http://www.acgme.org)

**American Association for Thoracic Surgery**
500 Cummings Center, Suite 4550
Beverly, MA 01915
Telephone: 978-927-8330
Fax: 978-524-8890
Website: [www.aats.org](http://www.aats.org)
American Board of Thoracic Surgery
633 North St. Clair Street, Suite 2320
Chicago, IL 60611
Telephone: 312-202-5900
Fax: 312-202-5960
Website: www.abts.org

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
Telephone: 800-621-1773
Fax: 312-202-8200
Website: www.osteopathic.org

American Osteopathic Board of Surgery
4764 Fishburg Road, Suite F
Huber Heights, OH 45424
Telephone: 937-235-9786
Fax: 937-235-9788
Website: www.aobs.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: www.cms.hhs.gov

DNV Healthcare, Inc.
1400 Ravello Drive
Katy, TX 77449
Telephone: 281-396-1000
Website: www.dnvaccreditation.com

Healthcare Facilities Accreditation Program
142 East Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: www.hfap.org

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Fax: 630-792-5005
Website: www.jointcommission.org
The Society of Thoracic Surgeons
633 N. Saint Clair Street, 23rd Floor
Chicago, IL 60611
Telephone: 312-202-5800
Fax: 312-202-5801
Website: www.sts.org

Thoracic Surgery Directors Association
633 N. Saint Clair Street, 23rd Floor
Chicago, IL 60611
Telephone: 312-202-5819
Fax: 312-202-5829
Website: www.tsda.org

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