The Society of Thoracic Surgeons Expert Consensus Statement: A Tool Kit to Assist Thoracic Surgeons Seeking Privileging to Use New Technology and Perform Advanced Procedures in General Thoracic Surgery

Shanda H. Blackmon, MD, MPH, David T. Cooke, MD, Richard Whyte, MD, Daniel Miller, MD, Robert Cerfolio, MD, Farhood Farjah, MD, MPH, Gaetano Rocco, MD, Matthew Blum, MD, Stephen Hazelrigg, MD, John Howington, MD, Donald Low, MD, Scott Swanson, MD, James I. Fann, MD, John S. Ikonomidis, MD, PhD, Cameron Wright, MD, and Sean C. Grondin, MD, MPH

Division of General Thoracic Surgery, Mayo Clinic, Rochester, Minnesota; Section of General Thoracic Surgery, University of California, Davis Medical Center, Sacramento, California; Division of Thoracic Surgery, Beth Israel Deaconess Medical Center, Boston, Massachusetts; Division of Thoracic Surgery, WellStar Health System, Marietta, Georgia; Division of Cardiothoracic Surgery, University of Alabama at Birmingham, Birmingham, Alabama; Division of Cardiothoracic Surgery, University of Washington, Seattle, Washington; National Cancer Institute, Pascale Foundation, Naples, Italy; Division of Thoracic Surgery, Memorial Hospital-University of Colorado Health, Colorado Springs, Colorado; Department of Surgery, Southern Illinois University, Springfield, Illinois; Division of Thoracic Surgery, NorthShore University Health System, Evanston, Illinois; Esophageal Center of Excellence, Virginia Mason Medical Center, Seattle, Washington; Division of Thoracic Surgery, Brigham and Women's Hospital/Dana-Farber Cancer Institute, Boston, Massachusetts; Department of Cardiothoracic Surgery, Stanford University, Stanford, California; Division of Cardiothoracic Surgery, Medical University of South Carolina, Charleston, South Carolina; Division of Thoracic Surgery, Massachusetts General Hospital, Boston, Massachusetts; and Division of Thoracic Surgery, University of Calgary, Foothills Medical Centre, Calgary, Alberta, Canada

Preamble

In the United States, the Centers for Disease Control and Prevention estimates more than 50 million procedures are performed every year [1]. In the era of physician report cards, transparency, medical innovation, increased litigation, and hybridization or cross-disciplinary nature of surgery, privileging for new technology continues to lack a standardized process for implementation. With the absence of established national standards to direct granting of privileges for new technology, The Society of Thoracic Surgeons (STS) convened a task force to address this problem and create a pathway, checklist, and list of recommendations to guide the process.

This consensus statement reviews more than 19 new techniques or procedures that are direct extensions of thoracic surgery that a surgeon may not have trained to perform if he or she completed residency within the last 10 years and at least five new categories of techniques or procedures where surgeons are partnering with other specialties or are retraining to perform procedures that require a completely new skill set to perform. This void needs to be filled, and our task force set forth to begin the process.

Background

The purpose of privileging is to help ensure that clinicians provide high-quality and high-value health care in accordance with accepted standards of care and legal requirements. Ensuring appropriate privileging to use new technology or perform advanced procedures may be challenging because historical data are often unavailable to evaluate the relationship between the privileging process and the safety and quality of the health care services or patient outcomes. The main objective of The Society of Thoracic Surgeons (STS) Task Force on General Thoracic Surgery Privileging is to propose a consensus statement and, most importantly, a framework for thoracic surgery privileging as it pertains to new technology and advanced procedures. It is not the purpose or intent of this task force to mandate specific criteria for privileging surgeons with respect to these subject matters.

Although the details for adopting new technologies may vary depending on practice location and environment, this practical framework may serve as a reference (and not a mandate) for surgeons and hospitals as they plan for the safe introduction and implementation of new technologies and advanced procedures. The framework is intended to be sufficiently broad so that it is relevant to a range of

REPORT

The STS Executive Committee approved this document.

Address correspondence to Dr Blackmon, Division of General Thoracic Surgery, Mayo Clinic, 200 First St, MA 12-54W, Rochester, MN 55905; email: blackmon.shanda@mayo.edu.

The Appendix can be viewed in the online version of this article [http://dx.doi.org/10.1016/j.athoracsur.2016.01.061] on http://www.annalsthoracicsurgery.org.

institutional settings and scopes of practice. Purposefully, the task force based its proposals on published literature or expert consensus and avoided attaching a mandatory number of cases performed in the privileging process. The task force concluded that, in most instances, little or no quality data are available for most new technology and advanced procedures to support assigning a specific number of cases for privileging. Consequently, the task force determined that in this context, privileging should be based on evaluation and documentation of knowledge and skills, continuous clinical and quality outcomes assessment, use of optimal clinical and administrative care processes, and in the case of new privileges, a focused professional practice evaluation (FPPE).

Consensus statements are generally derived from a systematic approach and an extensive literature review where highest-quality evidence does not commonly exist. A modified Delphi approach was taken as each suggestion or topic was chosen.

We reviewed the literature to explore a standard certification guide that could be incorporated into hospital bylaws and policies for the use of new technology and advanced procedures and identified four common goals of privileging, these being to develop (1) clear lines of responsibility for the privileging process, (2) supportive governance structures, (3) accepted standards for privileging, and (4) a culture of continuous improvement and evaluation of privileging process outcomes [2–5].

In this consensus statement, the task force clarifies some of the terminology associated with the privileging process and provides a description of the proposed framework for new technology and advanced procedures. We also categorize a representative list of new technology and advanced procedures in general thoracic surgery to which a framework may be applied and present case studies to illustrate how a framework checklist can assist in privileging a surgeon or a surgical team, or both.

Terminology

To develop an effective framework for privileging, one must be familiar with the common language regarding several relevant processes, including certification, credentialing, and privileging.

Certification

Certification in thoracic surgery in the United States is under the auspices of the American Board of Thoracic Surgery (ABTS), whose primary purpose is to protect the public by establishing and maintaining high standards of care in thoracic surgery, much like certifying boards in other countries. To achieve these objectives, the ABTS has developed highly specific qualifications for examinations as well as procedures for certification and maintenance of certification [6]. The ABTS board certification, which is a minimum requirement for all thoracic surgeons at most institutions in the United States, does not currently include specific guidelines for credentialing or for privileging board-certified or board-eligible surgeons in the use of new technology or acquisition of new and advanced skills. The American Board of Surgery also certifies general surgeons to perform procedures that are duplicated in ABTS certification. Individual hospitals then determine what level of certification is required for practice within their own institutions.

Credentialing and Privileging

Credentialing and privileging are institution-specific processes that culminate in recognizing and attesting that a thoracic surgeon is competent and qualified. Credentialing claims the thoracic surgeon meets universally recognized standards by verifying such items as the individual's education, license, training, experience, certification, malpractice history, adverse clinical reports, clinical judgment, and professionalism through investigational query, attestations, and observation.

Privileging defines the surgeon's scope of practice and the clinical services he or she may provide. Privileging should be based on competence, accompanied by a data-driven process, and centered on continuous quality improvement. The Joint Commission requires that physicians seeking new privileges undergo a defined FPPE [7]. The Joint Commission requirements for an FPPE are clear "criteria for conducting performance [evaluations, defined] methods for establishing a monitoring plan specific to the requested privilege [and] determining the duration of performance monitoring, [and documenting] the circumstances under which monitoring by external" individuals is necessary [7]. The FPPE can be set to occur after a set amount of time in practice or after a set amount of cases have been performed. An example of an FPPE form is shown in the Appendix.

Historically, individual hospitals have determined the criteria for granting privileges within a specialty, an approach that may result in wide variability in training and expertise. A hospital that has granted privileges to a provider has a duty to terminate or limit those privileges once it is made aware of incompetence [8]. Furthermore, in most instances, the patient does not have access to the institutional criteria necessary for granting privileges, because they are not a matter of public record [9].

To be fair, "credentialing and privileging must be products of qualified and objective physician-controlled peer review using criteria that are established through common professional," administrative, and legal practices. These criteria should be "endorsed by a formal consensus process and be available to the public in the form of hospital bylaws, procedures, or other documentation." Importantly, these criteria should be related to the quality of patient care, documented physician outcomes, and performance that can be measured. "Peer review decisions must be performed in good faith (not unreasonable, capricious, or arbitrary), fair, include detailed documentation, be justifiable, and be equally applied to all practitioners without bias" in accordance with reasonable standards of care. "Peer review decisions should be confidential and protected. In cases of adverse peer review decisions, avenues of appeals using due process and the inclusion of fair hearings must be available to the" surgeon undergoing the evaluative process