



University of Michigan  
Hospitals and Health Centers

**Delineation of Privileges  
Department of Cardiac Surgery  
Department of Surgery/Section of Thoracic Surgery**

**Name:** \_\_\_\_\_  
Please print or type

**CORE PRIVILEGES**

- Requested (Applicant)**       **Recommended approval (Service Chief/Chair)**

**Minimum Training and Experience**

M.D. or D.O. degree. Successful completion of an approved residency training program in general surgery followed by an Accreditation Council for Graduate Medical Education (ACGME) - approved residency training program in thoracic surgery.

For those joining the staff immediately after completion of thoracic surgery residency: A letter of reference from the director of the residency program at which the applicant trained documenting satisfactory completion of the program (including adequate case volume and demonstration of competency in patient care required by the American Board of Thoracic Surgery prior to its certifying examination); two additional supporting letters from thoracic surgery faculty of the candidate's residency program. Certification by the American Board of Thoracic Surgery within three years of the initial appointment to this staff is required.

For those joining the staff after having already been practicing thoracic surgery elsewhere: a letter of reference from the applicant's most recent service chief documenting adequate clinical volume (a minimum of 50 major thoracic surgical operations in the previous 12 months) and competency in patient care and two additional supporting letters from thoracic surgeons who have known the applicant for at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of thoracic surgery. Certification by the American Board of Thoracic Surgery is required. To retain privileges a minimum of 50 operations during a 12 month period is required.

**Scope of Practice/Privileges**

Privileges include the admission, diagnostic evaluation, consultation, and treatment of patients, including neonates, with thoracic surgical diseases as defined by the American Board of Thoracic Surgery in its 2006 Booklet of Information: "Thoracic Surgery encompasses the operative, perioperative, and surgical critical care of patients with acquired and congenital pathologic conditions within the chest. Included is the surgical repair of heart lesions, and congenital and acquired conditions of the heart, valves, and myocardium. It also includes pathologic conditions of the lung, esophagus and chest wall, abnormalities of the great vessels, tumors of the mediastinum, and diseases of the diaphragm and pericardium. Management of the airway and injuries to the chest are also within the scope of the specialty."

The scope of thoracic surgery encompasses a knowledge of normal and pathologic conditions of both cardiovascular and general thoracic structures. This includes congenital and acquired lesions (including infections, trauma, tumors, and metabolic disorders) of both the heart and blood vessels in the thorax, as well as diseases involving the lungs, pleura, chest wall, mediastinum, esophagus, and diaphragm. In addition, the ability to establish a precise diagnosis, an essential step toward proper therapy, requires familiarity with diagnostic procedures such as cardiac catheterization, angiography, electrocardiography, echocardiography, imaging techniques, endoscopy, tissue biopsy, and biologic and biochemical tests appropriate to thoracic diseases. It is essential that the thoracic surgeon be knowledgeable and experienced in evolving techniques, such as laser therapy, endovascular procedures, electrophysiology procedures and devices, thoracoscopy and thoracoscopic surgery.

**Privileges also include the following representative list, but it is not intended to be all-encompassing, but rather to reflect the categories/types of patient problems included in the description of privileges.**

Abdominal aorta, repair/reconstruction; Ablative surgery for: ventricular arrhythmia; Wolff-Parkinson-White syndrome; Achalasia surgery

Admit, evaluate, diagnose, consult, manage and treat all patients over one year of age with illnesses, injuries, diseases and disorders of the thoracic cavity and related structures, including the chest wall.

Anastomosis: - chest; - neck; Antireflux procedures; ARDS (adult respiratory distress syndrome); Arrhythmias (ablation), surgery; Arteriosclerotic vessels, surgery for correction or palliation; Artificial heart and mechanical devices to support or replace, implantation of; Atelectasis

Batista heart surgery; Bilobectomy, lung; Bronchial repair; Broncho-pleural fistula, closure; Bronchoplasty Bronchotomy; Bullectomy repair

Cardiac laceration, repair; Cardiac Pacing; Cardiac tumor; Cardiac valve replacement; Cardiopulmonary bypass; Cardiovascular repair, including: - foreign body removal; - laceration; - perforation; Cardiovascular shunt; Cardioverter defibrillator, implantation; Carinal resection; Cavernostomy; Chest/neck trauma management; Chest wall biopsy; Chest wall hernia repair; Chest wall reconstruction, including: - Pectus; - plastic; Chest wall resection; Chylothorax: - required drainage; - required surgical intervention; Closed heart surgery, including: - acquired; - congenital; - reconstruction w/grfts; Coarctation of the aorta, surgery Coronary artery fistula repair; Coronary revascularization; Correction of diaphragmatic hernias; including but not limited to: antireflux procedures; - congenital or acquired

Decortication or pleurectomy procedures; Diagnostic procedures, including: - cervical exploration; - mediastinal exploration; - mediastinoscopy; - parasternal exploration; Diaphragm reconstruction; Diaphragm resection; Diaphragm, plication of; Diaphragmatic hernia repair, including: - acquired; - congenital; - traumatic

Empyema, drainage (rib resection/Eloesser flap); Endobronchial lesion, use of laser; Endoscopy Esophageal atresia, correction ; Esophageal conduit, including: - colon; - gastric; - jejunum; Esophageal diverticulum operations; Esophageal drainage, surgery; Esophageal fistula, closure; Esophageal fundoplication: - circumferential; - partial; Esophageal gastroplasty; Esophageal perforation/rupture, repair or drain; Esophageal stent placement; Esophageal wall lesion resection; Esophagectomy, including: - transhiatal; Esophagogastric foreign body removal; Esophagoscopy, flexible/rigid; Esophagoscopy and dilatation for benign or malignant disease; Esophagostomy, including: - anterior thoracic; - cervical; Esophagus dilation

Flexible Fiberoptic bronchoscopy, including: - brushings; - forceps biopsy; - lavages; - routine biopsy; - transbronchial needle biopsy

Gastrectomy; Gastrostomy

Heart transplantation; Heart wound/injury, suture; Hydatid cyst resection

Ileus; Image guided intrapleural thoracic procedures; Interpretation of imaging studies to include: - computed tomography; - radionuclide; - roentgenographic; - ultrasound; Interpretation of studies to include: - cardiac catheterization; - esophageal function; - pulmonary function; Intra-aortic balloon pump, insertion, patient management, removal; Intracardiac congenital defects, correction of; Intrathoracic aneurysm, repair; Intrathoracic diverticulum resection; IVC, repair/reconstruction

#### Jejunostomy

Laparoscopy; Laparotomy; Laser bronchoscopy; Laser esophagoscopy; Left atrium, repair/reconstruction; Lobectomy, lung; Lung abscess, drainage; Lung donor harvest; Lung laceration/injury, repair; Lung radiofrequency ablation; Lung transplant: - double; - single; Lung volume reduction surgery: - median sternotomy; - thoracoscopic; Lung wedge resection: - multiple; - single

Management of acquired cardiac disease including – acquired septal defects, coronary arteries, surgery on pericardium, valves and other internal heart structures, ventricular aneurisms; Mediastinal abscess, drainage; Mediastinal lymph node: - biopsy; - dissection; - sampling; Mediastinal mass: - biopsy; - resection; Mediastinoscopy, including: - extended cervical; Mediastinotomy, anterior; Mediastinum surgery for removal of benign or malignant tumor; Minimally invasive port access operations; Myocardial infarction; Myocardial revascularizations; Myotomy, including: - cardia (short); - cricopharyngeal; - esophageal (long)

#### Neck trauma, management

Omental flap; Open heart surgery, including: - acquired; - congenital; - reconstruction w/grfts or transplantation; - replacement; - valvuloplasty

Palliative vascular procedures for congenital cardiac disease (not requiring cardiopulmonary bypass); Patent ductus arteriosus (PDA); Patent ductus ligation; Pectus repair; Pericardial drainage procedures; Pericardiectomy; Pericardiocentesis; Pleura decortications; Pleura thoracentesis; Pleural biopsy; Pleural drainage procedures; Pleural tumor, resection; Pleurectomy; Pleurodesis; Pleuroscopy (Medical Thoracoscopy); Pneumonectomy, including: - completion; - extrapleural; - intrapericardial; - standard; Pneumonia; Procedures on chest wall, lungs, including: lobectomy, pneumonectomy for benign or malignant disease, segmental resections, wedge sections; Pulmonary artery, repair/reconstruction; Pulmonary cyst, resection; Pulmonary embolectomy; Pulmonary reintubation; Pulmonary vein(s), repair/reconstruction; Pyloromyotomy; Pyloroplasty

Resection of esophagus for benign or malignant disease; Rib resection, including: - first/cervical; - rib mass; - single

Segmentectomy, lung; Sleeve bronchial resection; Sternal fracture repair; Sternectomy: - complete - partial; Sternotomy, including: - median; - partial; - transverse; Surgery on mediastinum for removal of benign or malignant tumor; Surgery of – patent ductus arteriosus, coarctation of aorta, aortic arch and branches, descending thoracic aorta for aneurysm/trauma, thoracoabdominal aorta for aneurysm; SVC, repair/reconstruction; Sympathectomy

TE fistula repair; Thoracentesis; Thoracic aorta, repair/reconstruction; Thoracic duct ligation; Thoracic muscle flaps: - latissimus; - pectoralis; - serratus; - myocutaneous; Thoracic outlet; Thoracic surgery, video-assisted; Thoracoplasty; Thoracoscopy, including: - hemorrhage exploration; - laser; - mediastinoscopy; - pacemaker implant; - pericardium drainage; - Scalene Node biopsy; - tracheostomy; Thoracotomy for: - anterior spinal fusion; -bleeding/not postoperative; -empyema drainage; -exploration; -foreign body removal; -hemorrhage; -rib biopsy; -sympathectomy; -transthoracic vagotomy; -trauma; Thrombosis, deep venous; Thymectomy; Tracheal stricture resection; Tracheal tumor resection; Tracheal/bronchial stent; Tracheo-esophageal fistula, correction; Tracheobronchial bronchoscopy, flexible/rigid; Tracheobronchial foreign body

removal; Tracheobronchial repair, laceration or rupture; Tracheostomy, including: - mediastinal; Tube thoracostomy

Vagotomy, transthoracic; Valvulotomy, closed; Varices, ligation; Vascular access procedures for: life support systems usage (i.e., extra corporeal oxygenation, cardiac support); Vascular aneurysm, repair or excision; Vascular embolectomy; Vascular graft; Vascular prosthesis; Vent support, initial >48 hours

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## LEVEL II

### THORACOSCOPY

- Requested (Applicant)**       **Recommended approval (Service Chief/Chair)**

(Adopted from the Video-assisted thoracic surgery (VATS) guidelines developed by the Joint Committee on VATS of the Society of Thoracic Surgery and the American Association for Thoracic Surgery)

#### **Minimum Training and Experience**

These privileges require additional specialty training and documentation evidence that the applicant has received recognized postgraduate training or completed a preceptorship. If documentation is not attached, no special privileges are granted.

To be granted privileges in thoracoscopy and video-assisted thoracic surgeons, surgeons must:

- (1) Be fully qualified to perform the procedure by the open method, and to handle potential complications of the procedure.
- (2) Document that education in VATS has been obtained. This can be either documentation of attendance at a course which conforms to the guidelines of the Joint Committee on VATS of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery, or a letter from the Director of the approved Thoracic Residency Program from which the surgeon has graduated. This letter should confirm that the surgeon is qualified to perform VATS procedures, based on experience and knowledge about the indications, contraindications and potential complications. Documentation of education in VATS should remain on file in the administrative offices of the institution that grants privileges.
- (3) Perform at least ten VATS procedures successfully during residency (ABTS requirement) or under observation by a qualified surgeon who certifies the applicant's competence to perform VATS. Whenever possible, the certifying surgeon and the applicant should be administratively and economically independent of each other.
- (4) Provide regular documentation of subsequent VATS cases performed in a manner that is consistent with the policy that governs other operations at the institution that is granting privileges. The outcome of VATS procedures is to be reviewed by the Quality Assurance Committee periodically, as required by the Department.

*Reappointment: Must perform a minimum of 10 VATS cases since the last appointment or reappointment.*

## **ENDOBONCHIAL ULTRASOUND**

- Requested (Applicant)**
- Recommended approval (Service Chief/Chair)**

These privileges require additional specialty training and documentation evidence that the applicant has received recognized postgraduate training or completed a preceptorship. If documentation is not attached, no special privileges are granted.

To be granted privileges in endobronchial ultrasound (EBUS), thoracic surgeons (whose residency training required competency in traditional bronchoscopy) must document that training in EBUS was obtained during either a Thoracic Surgery residency or through a postgraduate course followed by perceptorship. This can be either documentation of attendance at a course which conforms to the guidelines of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery, or a letter from the Director of the approved Thoracic Residency Program from which the surgeon has graduated. The preceptorship experience requires at least 5 mentored procedures.

Number per year to maintain privileges: 2

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## **ENDOVASCULAR THERAPY OF THE AORTA**

- Requested (Applicant)**
- Recommended approval (Service Chief/Chair)**

### **Minimum Training and Experience**

All faculty who qualify for endovascular therapy:

Must meet Level I requirements.

Faculty within one year of fellowship:

Must have completed a fellowship including interventional catheter based training of at least 6 months through 12/31/05, and one year thereafter. The fellowship must conform to the requirements of JACC 2004; 44(4):941-957 for "Training Requirements for Vascular Surgeons". In addition, the faculty must have the minimum case volumes specified below for "Practicing Endovascular Surgeons".

For Practicing Endovascular Surgeons

For faculty who are endovascular competent and have been practicing endovascular surgery, case volumes in the preceding two years is the same as for trainees and is as follows:

100 (50 as primary operator) – Diagnostic angiography

50 (25 as primary operator) - Arterial and venous angioplasty/stent placement

10 - Thrombolytic therapy

10 - Intravascular ultrasound

5 - Arterial and venous embolization

10 (5 as primary operator) - Thoracic or abdominal aortic stent grafting

For those joining the staff after having initially practiced Endovascular Surgery elsewhere: A letter of reference from the applicant's most recent service chief documenting adequate case volume & demonstration of competency.

For Practicing Cardiovascular Surgeons

For faculty who have been practicing cardiovascular surgery and wish to be endovascular certified, requirements are:

1. Have successfully completed a minimum three-month fellowship / preceptorship providing intensive supervised experience in endovascular therapy as described in the ACC / ACP / SCAI / SVMB / SVS Clinical Competence Statement (JACC 2004; 44:941-957). The specific fellowship must be accredited or endorsed by a major surgical or radiological society as qualified to provide endovascular therapy training, and must meet the standards (or equivalent) of the Society for Vascular Surgery Endovascular Program Evaluation and Endorsement Committee ([http://www.vascularweb.org/CONTRIBUTION\\_PAGES/Education/EV\\_PEEC/index.html](http://www.vascularweb.org/CONTRIBUTION_PAGES/Education/EV_PEEC/index.html)).

2. As an alternate pathway, an applicant may receive equivalent training within an ACGME-accredited residency / fellowship that provides at least three months of dedicated intensive supervised experience in endovascular therapy. The completion of this required training must be within a 24-month period, and include the following:

- a. Training under proctorship of formally trained vascular interventionalist competent to perform full range of procedures.
- b. Written curriculum with goals and objectives.
- c. Regular written evaluations by proctor.
- d. Documentation of procedures and outcomes.
- e. Supervised experience in inpatient and outpatient vascular consultation settings.
- f. Procedural requirements for competency in all areas including:
  1. Diagnostic peripheral angiograms—100 cases (50 as primary operator).
  2. Peripheral interventions—50 cases (25 as primary operator).
  3. Thoracic or abdominal aortic stent grafting – 10 cases (5 as primary operator).
  4. Percutaneous thrombolysis-thrombectomy – 10 cases
  5. Arterial and venous embolization – 5 cases
  6. Intravascular ultrasound – 10 cases

For those renewing their clinical privileges:

Documentation by the service chief of satisfactory performance of patient care during the preceding year will be required. Performance of at least 25 peripheral vascular intervention cases annually with documentation of favorable outcomes and minimal complications. At the time of repriviliging, the Section Head of Cardiac Surgery will review all Departmental peer review and quality assurance activities for the previous privileging period and determine that such peer evaluation of performance has been satisfactorily met for repriviliging.

**Endovascular Therapy of the Thoracic and Abdominal Aorta**

- Requested (Applicant)**       **Recommended approval (Service Chief/Chair)**

**Scope of Practice/Privileges**

Endovascular therapy at the origins of branches of the thoracic and abdominal aorta incident to primary aortic interventions. This includes brachiocephalic, extracranial cerebral (carotid and vertebral), visceral, renal, and iliac branches, but does not include coronary and intracranial arteries.

Endovascular therapy of central venous structures.

Endovascular therapy includes percutaneous radiological techniques such as, but not limited to, vascular occlusion techniques, vascular recanalization techniques, and placement of implantable devices (such as stents).

Endovascular privileges include diagnostic procedures incident to primary aortic interventions, such as angiography involving catheterization and injection of contrast into arteries.

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## Implantation of Ventricular Assist Devices

- Requested (Applicant)       Recommended approval (Service Chief/Chair)

[Adapted from the VAD program certification of the Joint Commission]

All faculty who qualify for implanting ventricular assist devices :  
Must meet Level I requirements.

Must be trained under proctorship of a qualified cardiothoracic surgeon competent to perform the full range of procedures.  
Must perform and document ten (10) procedures and their outcomes.  
Must have supervised experience in inpatient and outpatient consultation settings.

### Faculty renewing their privileges

Must have successfully placed ten (10) ventricular assist devices in the last 24 months with current activity in the last year.

### **SPECIAL PRIVILEGES**

**A separate application is required to APPLY or REAPPLY for the following Special Privileges:**

- ▶ FLUOROSCOPY
- ▶ LASER
- ▶ ROBOTIC SURGICAL PLATFORM
- ▶ SEDATION PRIVILEGES FOR A NON-ANESTHESIOLOGIST

PLEASE go to URL: [www.med.umich.edu/i/oca](http://www.med.umich.edu/i/oca) for instructions, or contact your Clinical Department Representative.

### **TO BE COMPLETED BY APPLICANT:**

I meet the previously stated criteria and request that my application be considered for the privileges as outlined above. I authorize and release from liability, any hospital, licensing board, certification board, individual or institution who in good faith and without malice, provides necessary information for the verification of my professional credentials for membership to the Medical Staff of The University of Michigan Health System.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DEPARTMENT ACTION**

Approval:      As Requested                                      As Modified

Explain any modifications:

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I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Justification for approval is based on careful review of the applicant's education, postgraduate clinical training, demonstrated clinical proficiency and Board Certification or qualifications to sit for the Boards.

Department Chair: \_\_\_\_\_ Date: \_\_\_\_\_

Service Chief: \_\_\_\_\_ Date: \_\_\_\_\_

**CREDENTIALS COMMITTEE**

**ACTION** Approval:      As Requested                                      As Modified

Explanation for any modification:

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**EXECUTIVE COMMITTEE ON CLINICAL AFFAIRS ACTION**

Approval:                      As Requested                                      As Modified.

Explanation for any modification:

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