OFFICIAL AMERICAN THORACIC SOCIETY DOCUMENTS HANDBOOK

These policies were approved by the ATS Board of Directors in May 2006 and updated in January 2025.

ATS
American Thoracic Society

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ATS DOCUMENT TYPES

Clinical practice guidelines

Clinical practice guidelines make diagnostic and treatment recommendations that assist physicians, other healthcare practitioners, and patients to make decisions about the appropriate course of action in specific clinical situations. They make four types of clinical recommendations: 1) who to treat, 2) which treatment to use, 3) who to perform diagnostic testing on, and 4) which diagnostic test to perform. As an example, see "Idiopathic Pulmonary Fibrosis (an Update) and Progressive Pulmonary Fibrosis in Adults: An Official ATS/ERS/JRS/ALAT Clinical Practice Guideline. Am J Respir Crit Care Med. 2022 May 1;205(9):e18-e47".

Clinical practice guidelines are developed by a multidisciplinary committee, which must include a guideline methodologist (i.e., an individual who has led the development of guidelines and systematic reviews using the Grading, Recommendations, Assessment, Development, and Evaluation [GRADE] approach). Guidelines may be conceptualized in two parts. The first part consists of 1) formulating and prioritizing clinical questions using the patient, intervention, comparator, outcome (PICO) format, 2) searching the literature, 3) selecting relevant studies, and 4) appraising and summarizing the evidence using the GRADE approach. The second part focuses on developing and grading recommendations using the GRADE approach, as well as writing the guidelines.

Systematic reviews performed in the context of guideline development may be published separately, following publication of the guidelines. The *Annals of the American Thoracic Society* has the right of first refusal (occasionally, the Documents Development and Implementation Committee may approve submission to the *American Journal of Respiratory and Critical Care Medicine)*. Systematic reviews follow a separate review and approval process from the guideline; they are subject to the editorial review process and decision of the journal, rather than the Documents Editor and the Board of Directors. Independently published systematic reviews must be registered in PROSPERO prior to initiation of the systematic review.

Clinical practice guidelines should be submitted within two years of the project start date. Guidelines may be a maximum of 10,000 words. A non-typeset online supplement can also be published on the journal's website (maximum of 20,000 words). Word limits are strictly enforced. The peer review process is overseen by the Documents Editor and is independent from the journals' review processes. Guidelines must be approved by the ATS Documents Editor and the Board of Directors.

Statements

There are four types of ATS statements: clinical statements, policy statements, research statements, and technical statements:

Clinical statements are like clinical practice guidelines in that they can make the same four types of clinical recommendations: 1) who to treat, 2) which treatment to use, 3) who to perform diagnostic testing on, and 4) which diagnostic test to perform. However, the recommendations can be informed by a pragmatic evidence synthesis rather than a systematic review. A pragmatic evidence synthesis differs from a systematic review in that one database is searched rather than multiple databases and both study selection and data extraction do not need to be done in duplicate. The GRADE approach is not required to write and grade recommendations. In addition, clinical statements can create clinical pathways, definitions, diagnostic criteria, classification schema, or answer exploratory questions. As an example, see "Approach to the Evaluation and Management of Interstitial Lung Abnormalities: An Official American Thoracic Society Clinical Statement.". Currently undergoing peer review and approval; confidential copy available upon request.

Policy statements present ATS positions on issues that pertain to bioethics, public health policy, health care financing and delivery, medical education, and governmental policy. They may make policy recommendations. Policy statements do not require a full or pragmatic systematic review of the literature. As an example, see "Moving toward Equitable Care for Sleep Apnea in the United States: Positive Airway Pressure Adherence Thresholds: An Official American Thoracic Society Policy Statement. Am J Respir Crit Care Med. 2023 Feb 1;207(3):244-254".

Research statements present ATS positions on issues that pertain to governmental funding of research, future research needs and initiatives, and other issues that promote or hinder pulmonary, critical care, and sleep research. They may make research recommendations. Research statements do not require a full or pragmatic systematic review of the literature. As an example, see "A Research Agenda to Improve Outcomes in Patients with Chronic Obstructive Pulmonary Disease and Cardiovascular Disease: An Official American Thoracic Society Research Statement. Am J Respir Crit Care Med. 2024 Sep 15;210(6):715-729".

Technical statements describe how to perform a test or procedure. They do not compare tests or procedures, nor do they identify populations to which a test or procedure should be applied. They may make "how to" recommendations. Technical statements should be based upon evidence, but they do not require a full or pragmatic systematic review of the literature. As an example, see "European Respiratory Society/American Thoracic Society technical statement: standardization of the

measurement of lung volumes, 2023 update. Eur Respir J. 2023 Oct 12;62(4):2201519".

Policy, research, and technical statements may make recommendations for policy, research, and how to perform a test, respectively; they may not make recommendations for patient care. Recommendations for clinical care can only be made within clinical statements and clinical practice guidelines.

Clinical statements should be submitted within two years of the project start date. Policy, research, and technical statements should be submitted within one year of the project start date. Statements may be a maximum of 10,000 words. A non-typeset online supplement can also be published on the journal's website (maximum of 20,000 words). Word limits are strictly enforced. The peer review process is overseen by the Documents Editor and is independent from the journals' review processes. Guidelines must be approved by the ATS Documents Editor and the Board of Directors.

Workshop reports

Workshop reports are summaries of conferences and workshops that were sponsored by the ATS. While most of the content in the report should derive from the conference or workshop, additional discussions and further development of ideas following the conference or workshop are acceptable. As an example, see "Precision Cut Lung Slices: Emerging Tools for Preclinical and Translational Lung Research. An Official American Thoracic Society Workshop Report. Am J Respir Cell Mol Biol. 2024 Nov 5;72(1):16–31".

Workshop reports may not make recommendations for patient care. They should be submitted within one year of the project start date. Workshop reports may be a maximum of 10,000 words. A non-typeset online supplement can also be published on the journal's website (maximum of 20,000 words). Word limits are strictly enforced. The peer review process is overseen by the Documents Editor and is independent from the journals' review processes. Guidelines must be approved by the ATS Documents Editor and the Board of Directors.

Figure 1 – Deciding upon the type of document

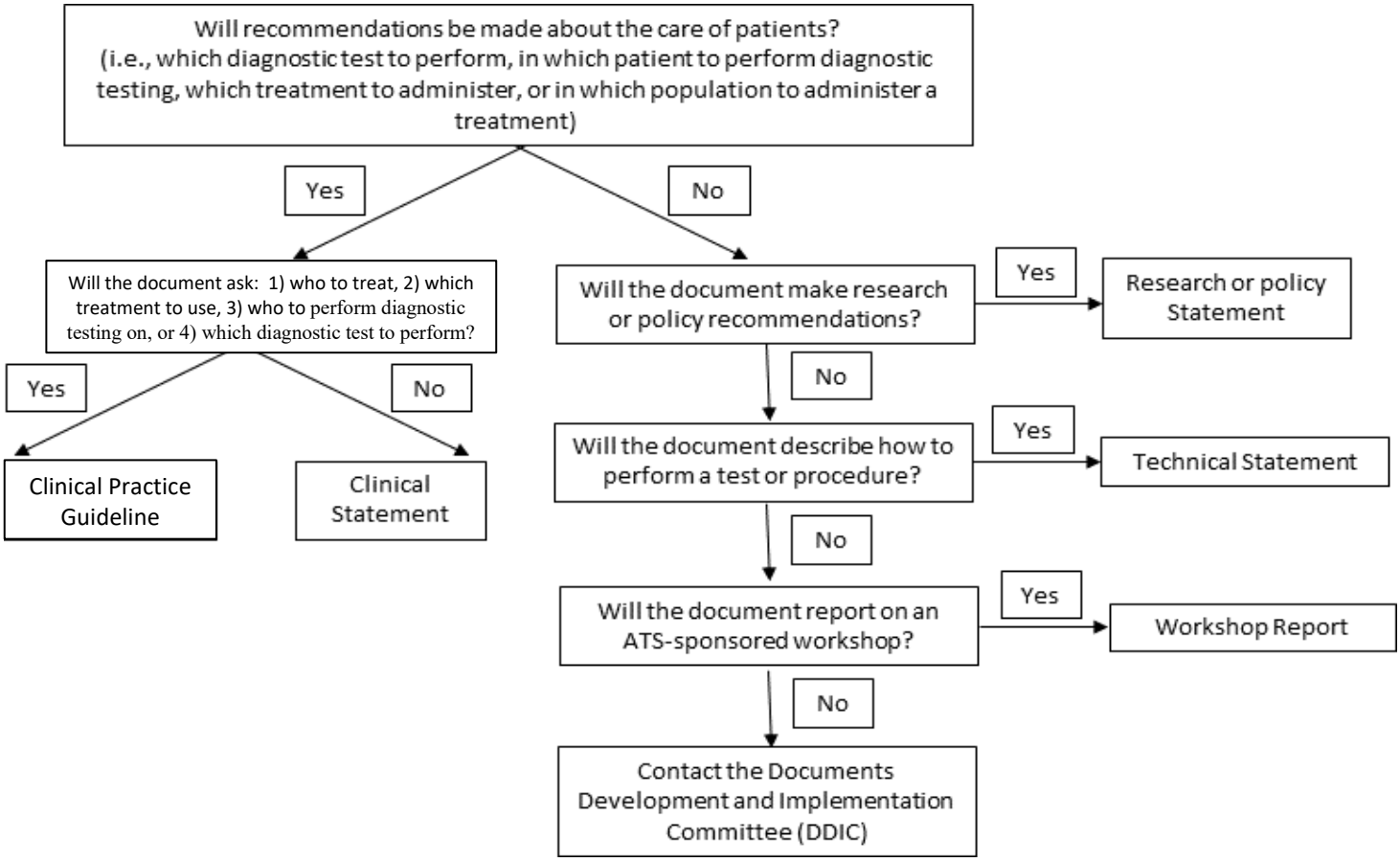

Table 1 – Comparison of the document types

Document		Clinical practice guideline	Clinical Statement	Policy Statement	Research Statement	Technical Statement	Workshop Report
Objective		Asks: 1) who to treat, 2) which treatment to use, 3) who to perform diagnostic testing on, or 4) which diagnostic test to perform.	Creates: 1) clinical pathways, 2) definitions, 3) diagnostic criteria, 4) classification schema, or 5) exploratory questions.	Present ATS positions on issues that pertain to bioethics, public health policy, health care financing and delivery, medical education, and governmental policy.	Present positions on issues that pertain to governmental funding of research, future research needs and initiatives, and other issues that promote or hinder research.	Describe how to perform a test or procedure.	Summaries of conferences and workshops that were sponsored by the ATS.
Methodological requirements	**PICO questions**	Required	Optional	Optional	Optional	Optional	Optional
	Evidence synthesis	Systematic review	Pragmatic evidence synthesis	Optional	Optional	Optional	Optional
	GRADE approach	Required	Optional	Optional	Optional	Optional	Optional
	Types of recommendations	Clinical	Clinical	Policy	Research	"How to"	None
Word count		10,000 word maximum	10,000 word maximum	10,000 word maximum	10,000 word maximum	10,000 word maximum	10,000 word maximum
Duration until submission		2 years	2 years	1 year	1 year	1 year	1 year

DOCUMENT DEVELOPMENT

Committee composition

The chair of approved projects must submit a list of committee members by February 15th. The following individuals must be included:

- Chair(s): The document development group should be led by one or more chairs who 1) understand the scope of the proposed project, 2) have the skills to lead the document development group, and 3) understand the methods required for the type of document being proposed. For clinical practice guidelines, the chair ideally will have been a participant in a previous ATS clinical practice guideline.

- Committee Members: Participants in the proposed project should represent the perspectives of healthcare professionals (i.e., patients, nurses, rehabilitation specialists, respiratory technicians, pharmacists, researchers, and ethicists) and organizations (i.e., regulators and payers) involved in the management of patients who will be affected by the document. Patients and/or patient advocates should be included. Documents aimed at an international audience should include international participants.

- Methodologist(s): Clinical practice guidelines require at least one methodologist, defined as an individual who has previously led a systematic review and the development of a guideline that used the GRADE approach. The individual(s) who will serve as the methodologist for the guideline project should be identified in the application. ATS staff are available to help identify potential methodologists. Clinical statements require an individual with experience leading a systematic review; the individual should be identified in the application and ATS staff are available to help identify such individuals.

Conflicts of interest

The chair and the proposed participants are then contacted by the ATS and asked to declare potential conflicts-of- interest. Such declaration of potential conflicts-of-interest is required of all individuals who can control the outcome of an official ATS project (in part or in full), including all project participants. The ATS Conflict-of-Interest Office reviews the participants' conflict-of-interest disclosures and then instructions for appropriate conflict-of-interest management are provided to the project chairs. ATS' conflict- of-interest policy requires that at least one chair and half the committee

be free of any relevant conflict-of-interest and remain free of such conflicts-of-interest for at least one year after publication. The chairs are responsible for ensuring that the required conflict-of-interest management steps are followed.

For policy statements, research statements, technical statements, and workshop reports, management usually consists of recusal of an individual from making recommendations and authoring portions of the document related to his or her relevant commercial interests.

For clinical practice guidelines and clinical statements, conflict-of-interest management is more rigorous. Participants are categorized as having no conflicts-of- interest, manageable conflicts-of-interest, or disqualifying conflicts-of-interest. Those with manageable conflicts will be allowed to participate in the guideline project but must be recused from making recommendations related to their conflicts. Those with disqualifying conflicts will be given the options of not participating in the project, terminating their relationship to participate in the project as an individual with a manageable conflict, or participating in the project as a non-voting expert contributor who cannot participate in making any recommendations.

Individuals may not participate in any activities related to the project until their conflict-of-interest disclosures have been submitted and reviewed.

Conflict-of-interest disclosures must be updated by committee members annually, when new relationships with industry develop, and when the final document is submitted for peer review. The chairs are responsible for periodically reminding the panel members of these requirements, requiring panel members to disclose new conflicts-of-interest at the beginning of each meeting or teleconference, and managing conflicts-of-interest throughout the development process.

Timeline

All official document types, except clinical practice guidelines and clinical statements, should be submitted within one year. As an example, a project that begins in 2026 is due for submission to the Documents Editor by December 31, 2026. Clinical practice guidelines and clinical statements should be submitted within two years. As an example, a clinical practice guideline that begins in 2026 is due for submission to the Documents Editor by December 31, 2027.

Responsibilities

Chairs are responsible for working with ATS staff to schedule the meetings and teleconferences,

running all meetings and teleconferences, and adhering with all of ATS' document development policies.

Annual Renewal

Project approval is for one year. A renewal application must be submitted annually for a project to be renewed. Renewal is not guaranteed, but rather, contingent upon evidence of satisfactory progress during the first year. Failure to submit a renewal application will result in inactivation of the project, which means that no funds will be provided, the document will not be accepted for review, and a new application will be required to re-activate the project.

Co-sponsorship

All projects are approved as ATS-only projects (with the only exception of those for which an ATS/ERS project application was submitted). Chairs who want their project to be co-sponsored by an additional organization must submit their request in writing to the Documents Editor before February 15th and should include the rationale and potential benefits of co-sponsorship. If the request is approved, the Documents Editor and Chief Executive Officer will work together to develop a Memorandum of Understanding with the other organization. No project is considered a joint project until the Memorandum of Understanding has been signed by all co-sponsoring societies. Chairs should not approach potential co- sponsoring organizations themselves; this should be done by ATS staff.

Confidentiality

Project participants must keep confidential any information that they learn from their participation until the document is published. The only exception is that a document may be presented at the ATS International Conference if it has been formally approved by the ATS Board of Directors, even if publication has not yet occurred. Subject to confidentiality are documents, data, drafts, charts, notes, reports, articles, pictures, drawings, discussions, plans or ideas, and intellectual property whether in written, verbal, digital, or other form. Participants will be asked to review the confidentiality policy and, if they cannot abide by the policy, to resign from the project. A breach of confidentiality determined by the ATS to have created a real or potential bias may result in the project being terminated.

Intellectual Property

Recipients agree, as a condition of receipt of ATS support, that the ATS owns the copyright and all other rights to any output created partly or completely with ATS funding, unless stipulated in writing by the ATS. The disposition of such products is at the sole discretion of the ATS.

Monitoring

Document development requires sustained, year-round effort. Document developers should expect periodic contact from the ATS Documents Editor, who will check-in to see how the document is progressing. Teleconferences are held periodically with ATS staff to discuss issues that emerge. The relevant Assembly Chairs, Assembly Planning Committees, Assembly Staff, Committee Chairs, and Committee Staff may also monitor the progress of the project. Developers are urged to be proactive in seeking advice as soon as questions or uncertainties arise. The following individuals are available to lend assistance:

- Kevin Wilson, Documents Editor, kwilson@thoracic.org (for issues related to interactions with other organizations; guideline methods; conflict of interest management; manuscript organization, submission, or review; or the Board of Directors)
- Judy Corn, ATS Staff, jcorn@thoracic.org (for general issues or issues related to the document-patient interface)
- John Harmon, ATS Staff, jharmon@thoraic.org (for issues related to project management and conflict of interest management)
- Rachel Kaye, ATS Staff, rkaye@thoracic.org (for issues related to scheduling or project management)
- Joseph Ruminjo, ATS Staff, jruminjo@thoracic.org (for issues related to guideline dissemination and implementation)

WRITING THE MANUSCRIPT

Official ATS documents are single documents; a project may not be divided into multiple documents.

Title page

Manuscripts should begin with a title page that provides the following information:

Title: Titles should end, ". . . : An Official American Thoracic Society [document type]" As an example, a title might read, "Treatment of Aspiration Pneumonia: An Official American Thoracic Society Clinical Practice Guideline."

Authors: The order of authors is determined by the chairs. Most commonly, one chair is first author, the other chair is last author, and other participants are listed either alphabetically or by contribution. Middle initials should be used. The list of authors should be followed by the phrase "on behalf of the [sponsoring ATS assembly]". The authorship policy is described in "Authorship" below.

Author affiliations: The authors' academic affiliations should be listed in the same order as the authors. The academic affiliations should be followed by ORCID numbers.

Corresponding author: The name, address, email address, telephone number, and fax number of the corresponding author should be provided.

Word count: The word count includes the introduction, methods, and body of the document. It does not include the title page, table of contents, abstract, overview section, references, tables, or figures. The word limits are provided in "Word count" below.

Key words: Three to five key words should be listed that are not in the document's title. Key words should be consistent with Medical Subject Headings (MeSH) terms, the vocabulary used by PubMed. The MeSH browser (http://www.ncbi.nlm.nih.gov/mesh) may be helpful for assigning key words.

Abstract

An abstract with a maximum of 250 words precedes a table of contents. For statements and guidelines, the abstract should describe the background, goals, methods, results, and conclusions. For workshop reports, the abstract may be unstructured.

Table of contents

All official ATS documents require a table of contents. The table of contents should list the document's first- and second-level headings.

Overview section

The overview section that consists of a single paragraph, followed by a bulleted list of key conclusions and recommendations. The overview section will probably be the most read portion of the document and should viewed as the authors' best opportunity to present their bottom-line and to entice readers to read more.

Body of document

The introduction and methods sections appear next. The methods section of all document types should indicate that "potential conflicts-of-interest were disclosed and managed in accordance with the policies and procedures of the ATS." For clinical practice guidelines and clinical statements, the methods section should describe committee formation, formulation of clinical questions, literature search strategies, and study selection criteria, as well as the methods used to appraise the evidence and formulate recommendations.

The remainder of the document should be organized as follows: body of the document, acknowledgements, attributions, and references. The attributions section should recognize the sponsoring Assembly (e.g., "This Statement was prepared by an ad hoc subcommittee of the [relevant assembly]"). All participants should then be listed, grouped by their role (e.g., chairs, methodologists, group leaders, committee members).

References

Document developers should cite the highest quality and most relevant literature. References should be updated periodically during the document development phase, as well as during the revision phase, since important literature may become available during those times. The number of references cited in a document is not limited.

Tables and figures

Tables and figures should not be embedded within the body of the manuscript. The tables should be placed after the references, followed by the figure legends. [Figures will be submitted as separate files and then electronically merged into a single PDF file along with the manuscript for review].

Online supplement

An online supplement is permitted; it should consist of its own title page, table of contents, body, and references.

Word counts

All official ATS documents can be a maximum of 10,000 words in length, counted from the introduction through the discussion. The abstract, table of contents, overview section, acknowledgement, attributions, references, table, and figures are not included in the word count. The online supplement can be a maximum of 20,000 words.

Conflict-of-interest disclosures

Authors do not need to include conflict-of-interest disclosures in their manuscript. ATS staff will draft a summary of conflict-of-interest disclosures once the document has been approved by the Documents Editor. The summary is based upon the disclosures made to ATS at the beginning of the project, during the annual renewal process, and when new industry relationships develop. This includes the disclosure of all commercial interests relevant to the subject matter or materials discussed in the manuscript. In addition, ICMJE disclosure forms must be submitted along with the manuscript.

DOCUMENT REVIEW AND APPROVAL

Submission

Manuscripts should be approved by all authors prior to submission. Documents are submitted to the Documents Editor using the Scholar One platform (http://mc.manuscriptcentral.com/atsdocs). Authors should be careful to select "American Thoracic Society Documents Review" rather than one of the journals when submitting their manuscript. Multi-society documents should be submitted to the lead society as determined at the start of the project.

Peer review

The review process for official ATS documents is independent from the ATS journals' review processes. The Documents Editor will perform an initial review of the document upon submission. If there are major flaws (e.g., not compliant with word limits, incorrect methodology used), the document will be returned to the authors with a description of what needs to be revised for the document to be ready for peer review. If the document is satisfactory, it will be sent for peer review by content experts.

Peer reviewers are selected by the Documents Editor, with input from the relevant assembly chair. The authors' preferred and non-preferred reviewers are also considered. Both domestic and international reviewers are typically sought to solicit a diversity of opinions. Most documents are reviewed by two to four peer reviewers, although the exact number is at the discretion of the Documents Editor. Peer review generally takes three to five weeks.

A decision letter will be issued following peer review, which is almost always a request for revisions. The decision letter includes comments from peer reviewers about content and from the Documents Editor about methodology and formatting/organization of the document. Authors are expected to consider each reviewer comment, make revisions deemed appropriate, and then resubmit the revised version of the document along with a point-by-point response to the reviewers' comments. Resubmission of revised manuscripts is expected within two months from the date the decision letter. The revised document and the point-by-point responses will be reviewed by the Documents Editor and/or the peer reviewers. Following this review, another decision letter will be issued, which is usually either a request for additional modifications or notification that the document has been accepted by

the Documents Editor. If any major conflicts between the Documents Editor and the chairs occur during the peer review process, the DDIC is responsible for the appropriate course of action. In cases where extreme conflict occurs, the ATS Executive Committee can be called upon to intervene.

Peer review is managed differently for multi-society projects. The document is submitted to the lead society, as designated in the Memorandum of Understanding. Following submission of the document, each society conducts its own peer review. The total number of reviewers and the time required for peer review are variable, although both are greater with more societies involved. The lead society collates the reviewer comments from the participating societies and then issues a single decision letter, which is usually a request for revisions. Authors are expected to consider each reviewer comment, make revisions deemed appropriate, and then resubmit the revised version of the document along with a point-by-point response to the reviewers' comments to the lead society. Cycles of peer review, decision letters, revisions, and resubmission continue until the co-sponsoring societies agree that the document is ready to be advanced to the leadership of each society for approval.

Board of Directors review and approval

Once approved by the Documents Editor, the document is sent to the Board of Directors for further review and a vote for or against approval at the next Board of Directors meeting. At the same time, the Documents Editor will request that all authors submit both an International Committee of Medical Journal Editors (ICMJE) conflict-of-interest disclosure and a copyright assignment form. The document will not be sent to the journal to be copyedited and prepared for publication until all forms are received. The journals do not conduct any additional review.

PUBLICATION SITE

ATS-only documents

Projects beginning prior to 2026 will be allocated as follows. Clinical practice guidelines, clinical statements, policy statements, research statements, and technical statements will be published in the *American Journal of Respiratory and Critical Care Medicine*. Most workshop reports will be published in the *Annals of the American Thoracic Society*, though workshop reports emphasizing basic science may be allocated to the *American Journal of Respiratory Cell and Molecular Biology*.

Beginning in 2026, the *American Journal of Respiratory and Critical Care Medicine* will review all clinical practice guidelines, clinical statements, policy statements, research statements, and technical statements and decide which to publish. If a document is not selected for publication by *American Journal of Respiratory and Critical Care Medicine,* it will be reviewed by the editors of the other ATS journals and an alternative publication site determined. Most workshop reports will continue to be published in the *Annals of the American Thoracic Society*, though workshop reports emphasizing basic science may be allocated to the *American Journal of Respiratory Cell and Molecular Biology* instead.

Joint documents

The publication site of ATS documents developed in collaboration with other professional societies is determined by the societies and not the authors. In the past, such documents were frequently published in duplicate in the journals of the participating societies. The ATS and most other societies no longer allow duplicate publication (see Publications Policy Committee Policy on Simultaneous Publications, 4/29/00), regardless of whether duplicate publication is simultaneous or staggered. Multi-society documents are published in either an ATS journal or the journal of the cosponsor(s), but not both.

The ATS recognizes that a prohibition against all forms of duplicate publication might hamper the dissemination of information to its members and that suspension of this policy may be warranted under extenuating circumstances. An example of these circumstances includes manuscripts that are developed in both English and a foreign language. Regardless of the rationale, duplicate publication must be approved by the ATS Executive Committee or Board of Directors.

To facilitate collaboration, the ATS has developed approaches with our most common partnering societies for assigning joint documents to a journal for publication. The approach varies, but may

include alternating publication sites, distributing documents according to the number and impact of the publications, and others. When an ATS document is published in another society's journal, it is common for an editorial to be published in an ATS journal that highlights and informs ATS members about publication of the ATS document in another society's journal.

IMPLEMENTATION

The ATS' commitment to a project does not end with its publication. The ATS is dedicated to ensuring that its clinical practice guidelines and clinical statements are maximally disseminated and implemented. The effort is coordinated by the ATS Director of Guideline Implementation, in conjunction with the chairs. Among dissemination and implementation efforts are the following: clinical summaries that are published in the *Annals of the American Thoracic Society*, including questions that provide Continuing Medical Education (CME) credits; an annual scientific symposium at the ATS International Conference to highlight new guidelines; summaries for inclusion several guideline repositories; patient information; pocket cards; videos; podcasts; and, in select cases, performance measures. These implementation tools are consolidated on dedicated implementation webpages created for each guideline. Chairs of guidelines may be asked to assist and provide feedback during the creation of these derivatives. The repertoire of dissemination and implementation activities continues to evolve.