

## Surgical critical care certification: generally speaking—it's thriving!

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**To cite:** Kaups KL. Surgical critical care certification: generally speaking—it's thriving! *Trauma Surg Acute Care Open* 2024;9:e001457. doi:10.1136/tsaco-2024-001457

Commentary on: Surgical critical care: Is work life expectancy increasing? An analysis of American Board of Surgery recertification rates across subspecialties.

As we consider the current surgical workforce and attempt to anticipate future needs, Dr Brigmon and colleagues are to be congratulated for their timely and thought-provoking analysis of trends in the surgical critical care (SCC) workforce.<sup>1,2</sup> Using American Board of Surgery (ABS) data on initial certification and recertification rates, the authors concluded that although the recertification rates in SCC are approximately 90%, this has remained lower than 10-year recertification rates in vascular surgery (96%) and pediatric surgery (99%), and even lower for 20-year recertification (up to 2017).

The authors hypothesize that 'less desirable' aspects of SCC practice (including long hours incorporating nights and weekends) are a potential cause for surgeons with initial SCC certification choosing to focus on other aspects of general surgery (GS) (and becoming less involved in SCC). However, in reviewing current trends and the increasing numbers of surgeons attaining SCC certification, it would appear that this is not consistent with the data. Review of the ABS website demonstrates an increasing number of SCC-certified and recertified surgeons.<sup>3</sup> Surgeons are, by nature, problem-solvers and accustomed to working in a team atmosphere. Thus, most intensivists find the collaborative and multidisciplinary nature of SCC practice attractive. The ability to work in a group practice with a team approach helps to mitigate the time demands and, by definition, unpredictability of critical care including the sudden, unanticipated deterioration and crises that occur. Surgeons practicing SCC are frequently recognized as the experts in their respective hospitals in crisis management (eg, the patient with uncontrolled hemorrhage, loss of airway, unknown source of sepsis).

As the relative recertification rates are examined, it is also important to consider that GS certification must be maintained to be eligible for SCC certification, unlike pediatric surgery and, since 2006, vascular surgery which have primary certification. Dependent on local hospital credentialing requirements, a surgeon may choose to continue with a single certification—rather than maintaining both certificates in GS and SCC. National hospital data on the proportion requiring current SCC certification to provide care for surgical patients in the intensive care unit (ICU) are lacking and may be difficult to determine. A recent article by Halpern and colleagues, reviewing the literature for definitions

of intensivists, found a lack of consistency in definition.<sup>4</sup> Interestingly, in this study, 'works in the ICU' and 'attending ICU physician' were most commonly used in the literature with board certification used in only 27% of studies and fellowship training in 22%. Relatively few studies (six included in Halpern's article) defined surgical intensivists, suggesting that the definition is more often related to location of practice rather than certification.

Brigmon and colleagues also comment on the gender disparity among SCC certificate holders (while noting equal recertification rates between genders); however, review of ABS data demonstrates that surgeons obtaining SCC certification during the last 10 years were 41% female—comparable with GS, and the highest percentage among those obtaining ABS specialty certification.<sup>1,3,5,6</sup>

Furthermore, with the transition from the every 10-year certification examination to the Continuing Certification Assessment, with its open-resource format and emphasis on continuing, relevant education, the rate of recertification is anticipated to increase further. We can anticipate that the number of SCC-certified surgeons will only continue to increase—and continue their essential contributions to the care of surgical patients.

**Contributors** KLK was the author of the commentary.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** None declared.

**Patient consent for publication** Not applicable.

**Ethics approval** Not applicable.

**Provenance and peer review** Commissioned; internally peer reviewed.

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► <http://dx.doi.org/10.1136/tsaco-2023-001299>

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