**Background**

Surgical critical care is a subspecialty of surgery that manages complex surgical and medical problems in critically ill surgical patients. The education of surgeons in the practice of surgical critical care encompasses didactic instruction in the basic and clinical sciences of surgical diseases and conditions, as well as education in procedural skills and techniques used in intensive care settings.

Board-certified physicians in surgery must complete a 12-month fellowship in surgical critical care before applying for subspecialty certification through the American Board of Surgery (ABS). The American Osteopathic Board of Surgery (AOBS) also grants certification of added qualification (CAQ) in surgical critical care.

For more information, please see *Clinical Privilege White Paper*, Practice area 161—General surgery.

**Involved specialties**

Critical care surgeons

**Positions of specialty boards**

**ABS**

To become certified in the subspecialty of surgical critical care through the ABS, physicians must:

- Be currently certified in general surgery by the ABS. The ABS will also accept applicants currently certified in vascular surgery who have completed an integrated training program. In addition, the ABS will accept current diplomates of other American Board of Medical Specialties surgical boards, provided their primary certifying board supports their application.
- Have a currently registered full and unrestricted license to practice medicine in the United States or Canada. Applicants are required to immediately inform the ABS of any conditions or restrictions in force on any active medical license they hold.
- Have satisfactorily completed a program in surgical critical care or anesthesiology critical care (48 weeks of full-time experience) accredited by the Accreditation Council for Graduate Medical Education (ACGME). At the discretion of the program director, the fellowship may be completed over two
consecutive years on a part-time basis. (The completed training in this part-time option must be equal to 48 weeks of full-time experience.)

- Be actively and primarily engaged in the practice of surgical critical care as indicated by holding full surgical privileges in this discipline in approved hospitals.
- Submit for review a detailed report regarding 50 patients cared for during the fellowship, including all deaths (up to 25 cases). Cases must be from the applicant’s fellowship and verified by the program director.
- Adhere to the ABS ethics and professionalism policy.
- Pass the surgical critical care certifying examination, a computer-based examination offered annually by the ABS.

Applicants who complete an ACGME-accredited surgical critical care or anesthesiology critical care fellowship after completing three progressive years of general surgery or integrated vascular surgery residency may apply for surgical critical care certification and take the exam while still in residency. A full and unrestricted medical license is not required at time of application. The certificate is not awarded, however, until certification in surgery or vascular surgery is achieved. When entering the surgical critical care program, applicants must have a guaranteed categorical residency position in an accredited general surgery or vascular surgery program available to them upon completion.

**AOBS**

To earn a CAQ in surgical critical care through the AOBS, physicians must:

- Be certified in general surgery or a surgical specialty by the AOBS
- Complete one year of surgical critical care training approved by the American Osteopathic Association (AOA) or the American College of Osteopathic Surgeons (ACOS)
- Pass a surgical critical care written examination

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

**ACS**

The American College of Surgeons (ACS) has a Committee on Trauma, which develops and implements programs for trauma care and offers information on verified trauma programs. The ACS does not publish specific training requirements for surgical critical care.

**AAST**

The American Association for the Surgery of Trauma (AAST) is a membership organization for trauma and acute care surgery specialists. Although its member may be certified in surgical critical care, the AAST does not publish specific requirements for training in the subspecialty.
ACGME

In its *Program Requirements for Graduate Medical Education in Surgical Critical Care*, the ACGME states that the educational program in surgical critical care must be 12 months in length and that fellows must have completed at least three clinical years in an ACGME-accredited graduate educational program in one of the following specialties: anesthesiology, neurological surgery, obstetrics and gynecology, orthopedic surgery, otolaryngology, surgery, thoracic surgery, vascular surgery, or urology. The fellowship curriculum must be organized as follows:

- All 12 months must be devoted to advanced educational and clinical activities related to the care of critically ill patients and to the administration of critical care units.
- At least eight months must be in a surgical ICU that is largely dedicated to the care of one or more of the following surgical patients: adult surgical, burn, cardiothoracic, neurosurgical, pediatric surgical, transplant, and trauma. At least five of these eight months should be in a unit in which a surgeon is director or codirector.
- No more than two months should be in nonsurgical ICUs, such as medical, cardiac, or pediatric units.
- No more than two months should be in elective rotations in areas relevant to critical care, such as trauma or acute care surgery. Elective clinical rotations done outside of the critical care unit should involve the care of patients with acute surgical diseases such as those related to injury or emergent surgical conditions.
- The core curriculum must include a regularly scheduled didactic program based on the core knowledge content and areas defined as a fellow’s outcomes in the specialty.
- Participation in direct operative care of critically ill patients in the operating room during critical care rotations should not be so great as to interfere with the primary educational purpose of the critical care rotation.
- Fellows must keep two written records of their experience: a summary record documenting the numbers and types of critical care patients; and an operative log of numbers and types of operative experiences, including bedside procedures.
- A chief resident in surgery and a fellow in surgical critical care must not have primary responsibility for the same patient.

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. With regard to patient care, fellows must have supervised training that will enable them to demonstrate competence in the following critical care skills:

- Circulatory: performance of invasive and noninvasive monitoring techniques, and the use of vasoactive agents and management of hypotension and shock; application of trans-esophageal and transthoracic cardiac ultrasound and transvenous pacemakers, dysrhythmia diagnosis and treatment, and the management of cardiac assist devices
- Endocrine: performance of the diagnosis and management of acute endocrine disorders, including those of the pancreas, thyroid, adrenals, and pituitary
Surgical critical care

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- Gastrointestinal: performance of utilization of gastrointestinal intubation and endoscopic techniques in the management of the critically ill patient; and management of stomas, fistulas, and percutaneous catheter devices
- Hematologic: performance of assessment of coagulation status, and appropriate use of component therapy
- Infectious disease: performance of classification of infections and application of isolation techniques, pharmacokinetics, drug interactions, and management of antibiotic therapy during organ failure; nosocomial infections; and management of sepsis and septic shock
- Monitoring/bioengineering: performance of the use and calibration of transducers and other medical devices
- Neurological: performance of management of intracranial pressure and acute neurologic emergencies, including application of intracranial pressure monitoring techniques and electroencephalography to evaluate cerebral function
- Nutritional: the use of parenteral and enteral nutrition, and monitoring and assessing metabolism and nutrition
- Renal: performance of the evaluation of renal function; use of renal replacement therapies; management of hemodialysis, and management of electrolyte disorders and acid-base disturbances; and application of knowledge of the indications for and complications of hemodialysis
- Respiratory: performance of airway management, including techniques of intubation, endoscopy, and tracheostomy, as well as ventilator management

Fellows must also demonstrate competence in the application of the following critical care skills:
- Circulatory: transvenous pacemakers; dysrhythmia diagnosis and treatment, and the management of cardiac assist devices; and use of vasoactive agents and the management of hypotension and shock
- Neurological: the use of intracranial pressure monitoring techniques and electroencephalography to evaluate cerebral function
- Renal: knowledge of the indications for and complications of hemodialysis, and management of electrolyte disorders and acid-base disturbances
- Miscellaneous: performance of the use of special beds for specific injuries, and employment of skeletal traction and fixation devices

With regard to medical knowledge, fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows must demonstrate advanced knowledge of the following aspects of critical care, particularly as they relate to the management of patients with hemodynamic instability, multiple system organ failure, and complex coexisting medical problems:
- Biostatistics and experimental design
- Cardiorespiratory resuscitation
- Critical obstetric and gynecologic disorders
- Critical pediatric surgical conditions
- Ethical and legal aspects of surgical critical care
- Hematologic and coagulation disorders
- Inhalation and immersion injuries
- Metabolic, nutritional, and endocrine effects of critical illness
- Monitoring and medical instrumentation
- Pharmacokinetics and dynamics of drug metabolism and excretion in critical illness
- Physiology, pathophysiology, diagnosis, and therapy of disorders of the cardiovascular, respiratory, gastrointestinal, genitourinary, neurological, endocrine, musculoskeletal, and immune systems, as well as of infectious diseases
- Principles and techniques of administration and management
- Trauma, thermal, electrical, and radiation injuries

AOA/ACOS

In their Basic Standards for Residency Training in Surgery and the Surgical Subspecialties, the AOA and ACOS state that surgical critical care residents must have completed an AOA-approved general surgery residency program, which includes the completion of an AOA-approved common surgical OGME-1R year. The length of the surgical critical care residency program is 12 months, nine of which must be dedicated exclusively to the management of adult critically ill surgical patients in the clinical setting. No more than three months of the 12-month program may be assigned outside the program. Elective assignments must be approved by the program director to permit the resident to pursue special interests.

A surgical critical care residency program must provide a meaningful education that prepares the resident upon graduation to meet certification requirements of the AOA and the AOBS, and to demonstrate the following competencies:

- **Cognitive**
  - Demonstrate the ability to develop a comprehensive plan of care for any critically ill patient; integrate the services of a multidisciplinary team, including specialists and subspecialists; and direct the scope of their involvement to ensure high quality of care for the patient without unnecessary duplication of services.
  - Demonstrate the ability to apply knowledge and understanding of each consultative specialty to provide competent patient care.

- **Psychomotor and technical skills**
  - Integrate osteopathic principles and practices throughout the course of training, when indicated.
  - Demonstrate technical skills in surgical critical care.
  - Provide competent physiologic management of the critically ill surgical patient in the intensive care and intermediate care units.

- **Communication skills**
  - Recognize the importance of problem-solving and conflict resolution among medical staff, resident staff, nursing staff, ancillary staff, and patients and their families.
• Practice management
  - Demonstrate the ability to manage a surgical critical care unit.
  - Demonstrate the ability to cooperate with other healthcare professionals from a wide variety of different medical specialties in a multidisciplinary team. The role must be either team manager or team member based upon need to deliver quality care.
  - Demonstrate the ability to allocate scarce resources, including triage decisions both for admission and discharges as a provider and as the unit director.

• Professional attitudes and abilities
  - Demonstrate the ability to treat the patient and family as beings and not just a disease entity.
  - Demonstrate an appreciation for the psychosocial aspects of critical surgical illness to prepare the patient to deal with the multifactorial impact of the illness on both the self and the family.
  - Demonstrate the ability to initiate or withdraw physiologic support while understanding the needs and concerns of diverse cultures and traditions relating to death and to medical care.
  - Act as an educational resource for the institution and community.
  - Assume the role of educator as preparation for a career-long obligation as a surgical educator.
  - Publication of clinical or basic science research in recognized journals and periodicals is strongly encouraged.

The program curriculum must meet or exceed the ACOS model curriculum and must provide residents with an advanced education in critical care management, including the following:

• The management of complicated critical care patients in a multi-disciplinary environment so as to function as a unit director following completion of the program
• Knowledge of the physiology, pathophysiology, and pathology of diseases involving the cardiovascular, respiratory, renal, gastrointestinal, hepatic, central nervous, immune, endocrine, and hematologic systems; as well as the therapy of diseases of each system, complex system interrelationships, and single system failure
• The role of hypermetabolism, the various mediators, and the pathophysiology and therapy of multiple organ system failure
• Current treatment modalities and equipment used in the care of critically ill patients
• Physiologic support for the critically ill surgical patient, including:
  - Ventilatory management with and without assist devices, including standard ventilatory modes, high-frequency ventilatory modes, and extracorporeal oxygenation
  - Pharmacological and mechanical cardiovascular support (for example, intra-aortic balloon pumps or left ventricular assist devices)
  - Renal support (for example, the various forms of dialysis, such as continuous arterial venous hemofiltration, peritoneal dialysis, and hemodialysis)
- Immune system support, including pharmacological interventions aimed at understanding the immune consequences of various other therapies and the endocrine response to injury and illness
- Metabolic nutritional assessment and support, including enteral and parenteral nutrition and nutritional assessment
  - Pharmacologic intervention, including inotropes, pressors, antibiotics, muscle paralyzing agents, sedatives, and narcotics, and their role in assisting recovery or creating morbidity
  - Knowledge of physiologic monitors and the technical skills to insert, calibrate, troubleshoot, and acquire data (for example, electrocardiogram, arterial lines, pulmonary artery catheters, oxymetric catheters, intracranial pressure monitors, compartment pressure monitors, and indirect calorimetry)
  - The ability to evaluate data from multiple sources and form a coherent picture of the pathophysiology of the disease

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for surgical critical care. 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 surgical critical care. 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 surgical critical care. 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 establish 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 surgical critical care. 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 surgical critical care

Basic education: MD or DO

Minimal formal training: Successful completion of ACGME- or AOA-accredited fellowship in surgical critical care and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in surgical critical care by the ABS or the AOBS.

Required current experience: At least 50 trauma surgeries/surgical critical care cases, reflective of the scope of privileges requested, in the past 12 months or successful completion of 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 surgical critical care

Core privileges for surgical critical care include the ability to admit, evaluate, diagnose, and manage patients of all ages presenting with acute, life-threatening, or potentially life-threatening surgical conditions by utilizing specialized expertise relating to both the physiologic responses to tissue injury from trauma, burns, operation, infections, acute inflammation, or ischemia, and to the ways these responses interact with other disease processes; this includes management of patients with hemodynamic instability, multiple system organ failure, and complex coexisting medical problems. Critical care surgeons may provide care to patients in the intensive care setting in conformance with unit policies, and can assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the following procedures and such other procedures that are extensions of the same techniques and skills.
• **Airway**  
  - Tracheotomy, open and percutaneous  
  - Cricothyroidotomy  
  - Nasal and oral endotracheal intubation, including rapid sequence induction

• **Head/face**  
  - Nasal packing  
  - Intracranial pressure monitoring  
  - Ventriculostomy  
  - Lateral canthotomy

• **Neck**  
  - Exposure and definitive management of vascular and aerodigestive injuries  
  - Thyroidectomy  
  - Parathyroidectomy

• **Chest**  
  - Exposure and definitive management of cardiac injury, pericardial tamponade  
  - Exposure and definitive management of thoracic vascular injury  
  - Repair blunt thoracic aortic injury (open or endovascular)  
  - Partial left-heart bypass  
  - Pulmonary resections  
  - Exposure and definitive management of tracheo-bronchial and lung injuries  
  - Diaphragm injury repair  
  - Definitive management of empyema, including decortication (open and video-assisted thoracic surgery [VATS])  
  - VATS for management of injury and infection  
  - Bronchoscopy, including diagnostic and therapeutic treatment for injury, infection, and foreign body removal  
  - Exposure and definitive management of esophageal injuries and perforations  
  - Spine exposure (thoracic and thoraco-abdominal)  
  - Advanced thoracoscopic techniques as they pertain to the above conditions  
  - Damage control techniques

• **Abdomen and pelvis**  
  - Exposure and definitive management of gastric, small intestine, and colon injuries  
  - Exposure and definitive management of gastric, small intestine, and colon inflammation, bleeding, perforation, and obstructions  
  - Gastrostomy (open and percutaneous) and jejunostomy  
  - Exposure and definitive management of duodenal injury  
  - Hepatic resections  
  - Management of splenetic injury, infection, inflammation, and diseases  
  - Management of pancreatic injury, infection, and inflammation  
  - Pancreatic resection and debridement  
  - Management of renal, ureteral, and bladder injury
Management of injuries to the female reproductive tract
Management of acute operative conditions in pregnant patients
Management of abdominal compartment syndrome
Damage control techniques
Abdominal wall reconstruction following resectional debridement for infection and ischemia
Advanced laparoscopic techniques as they pertain to the above procedures
Exposure and definitive management of major abdominal and pelvic vascular injury
Exposure and definitive management of major abdominal and pelvic vascular rupture or acute occlusion
Placement of inferior vena cava filter

**Extremities**
- Radical soft tissue debridement for necrotizing infection
- On-table arteriography
- Exposure and management of upper-extremity vascular injuries
- Exposure and management of lower-extremity vascular injuries
- Damage control techniques in the management of extremity vascular injuries, including temporary shunts
- Acute thrombo-embolectomy
- Hemodialysis access, permanent
- Fasciotomy, upper extremity
- Fasciotomy, lower extremity
- Amputations, lower extremity (hip disarticulation, AKA, BKA, Trans-met)
- Reduction of dislocations
- Splinting fractures
- Application of femoral/tibial traction

**Other procedures**
- Split- and full-thickness skin grafting
- Thoracic and abdominal organ harvesting for transplantation
- Operative management of burn injuries
- Upper-gastrointestinal endoscopy
- Colonoscopy
- Core rewarming (e.g., continuous arteriovenous rewarming and continuous venovenous rewarming)
- Diagnostic and therapeutic ultrasound

**Special noncore privileges in surgical critical care**

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 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 surgical critical care, the applicant must have current demonstrated competence and an adequate volume of experience (\([n]\) trauma surgery/surgical critical care cases) 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 surgical critical care should be required.

For more information

**Accreditation Council for Graduate Medical Education**
515 North State Street, Suite 2000
Chicago, IL 60610-4322
Telephone: 312-755-5000
Fax: 312-755-7498
Website: [www.acgme.org](http://www.acgme.org)

**American Association for the Surgery of Trauma**
633 N Saint Clair Street, Suite 2600
Chicago, IL 60611
Telephone: 800-789-4006
Fax: 312-202-5064
Website: [www.aast.org](http://www.aast.org)

**American Board of Surgery**
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103-1847
Telephone: 215-568-4000
Fax: 215-563-5718
Website: [www.absurgery.org](http://www.absurgery.org)

1. Healthcare organizations should define the minimum case/patient volume (the "\([n]\)"") required to maintain clinical competence as recommended by the applicable department chair and the medical executive committee and subject to approval by the governing body.
Healthcare Facilities Accreditation Program  
142 E. 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