



The

AMERICAN

BOARD

of

SURGERY

**Booklet of
Information
Surgery
2010–2011**

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of
SURGERY

Booklet of Information
Surgery



2010 – 2011

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The Booklet of Information – Surgery is published by the American Board of Surgery (ABS) to outline the requirements for certification in surgery. Applicants are expected to be familiar with these requirements and bear ultimate responsibility for ensuring their training complies with ABS requirements, as well as for acting in accordance with the ABS policies governing each stage of the certification process.

This edition of the booklet supersedes all previous publications of the ABS concerning its policies, procedures and requirements for examination and certification in surgery. The ABS, however, reserves the right to make changes to its fees, policies, procedures and requirements at any time. Admission to the certification process is governed by the policies and requirements in effect at the time an application is submitted and is at the discretion of the ABS.

Applicants should visit the ABS website at www.absurgery.org for the most recent updates.

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I. INTRODUCTION

A. Purpose of the ABS

The American Board of Surgery Inc. is a private, non-profit, autonomous organization formed for the following purposes:

- To conduct examinations of acceptable candidates who seek certification or maintenance of certification by the board.
- To issue certificates to all candidates meeting the board's requirements and satisfactorily completing its prescribed examinations.
- To improve and broaden the opportunities for the graduate education and training of surgeons.

The ABS considers certification to be voluntary and limits its responsibilities to fulfilling the purposes stated above. Its principal objective is to pass judgment on the education, training and knowledge of broadly qualified and responsible surgeons and not to designate who shall or shall not perform surgical operations. It is not concerned with the attainment of special recognition in the practice of surgery. Furthermore, it is neither the intent nor the purpose of the board to define the requirements for membership on the staff of hospitals or institutions involved in the practice or teaching of surgery.

B. History of the ABS

The American Board of Surgery was organized on January 9, 1937, and formally chartered on July 19, 1937. The formation of the ABS was the result of a committee created a year earlier by the American Surgical Association, along with representatives from other national and regional surgical societies, to establish a certification process and national certifying body for individual surgeons practicing in the U.S.

The committee decided that the ABS should be formed of members from the represented organizations and, once organized, it would establish a comprehensive certification process. These findings and recommendations were approved by the cooperating societies, leading to the board's formation in 1937. This was done to protect the public and improve the specialty.

The ABS was created in accordance with the Advisory Board of Medical Specialties, the accepted governing body for determining certain specialty fields of medicine as suitable for certification. In 1970 it became known as the American Board of

Medical Specialties (ABMS) and is currently composed of 24 member boards, including the American Board of Surgery.

C. The Certification Process

The ABS considers certification in surgery to be based upon a process of education, evaluation and examination. The ABS holds undergraduate and graduate education to be of the utmost importance and requires the attestation of the residency program director that an applicant has completed an appropriate educational experience and attained a sufficiently high level of knowledge, clinical judgment and technical skills, as well as ethical standing, to be admitted to the certification process.

Individuals who believe they meet the ABS' educational and ethical requirements may begin the certification process by applying for admission to the Qualifying Examination (QE). The application is reviewed and, if approved, the applicant is granted admission to the examination.

Upon successful completion of the Qualifying Examination, the applicant is considered a "candidate" for certification and granted the opportunity to take the Certifying Examination (CE). If the candidate is also successful at this examination, the candidate is deemed certified in surgery and becomes a diplomate of the ABS.

Possession of a certificate is not meant to imply that a diplomate is competent in the performance of the full range of complex procedures that encompass each content area of general surgery as defined in section I-D. It is not the intent nor the role of the ABS to designate who shall or shall not perform surgical procedures or any category thereof. Credentialing decisions are best made by locally constituted bodies and should be based on an applicant's extent of training, depth of experience, patient outcomes relative to peers and certification status.

D. Specialty of General Surgery Defined

1. The scope of general surgery

General surgery is a discipline that requires knowledge of and familiarity with a broad spectrum of diseases that may require surgical treatment. By necessity, the breadth and depth of this knowledge will vary by disease category. In most areas, the surgeon will be expected to be competent in diagnosing and treating the full spectrum of disease. However, there are some

types of disease in which comprehensive knowledge and experience is not gained in the course of a standard surgical residency. In these areas the surgeon will be able to recognize and treat a select group of conditions within a disease category.

2. The required residency experience for initial certification in general surgery

Residency training in general surgery requires experience in all of the following content areas:

- Alimentary Tract
- Abdomen and its Contents
- Breast, Skin and Soft Tissue
- Endocrine System
- Organ Transplantation
- Pediatric Surgery
- Surgical Critical Care
- Surgical Oncology (including Head and Neck Surgery)
- Trauma/Burns and Acute Care Surgery
- Vascular Surgery

General surgery as a field comprises, but is not limited to, the performance of operations. Additional expected knowledge and experience in the above areas includes:

- Technical proficiency in the performance of essential operations/procedures in the above areas, plus knowledge, familiarity and in some cases proficiency with more uncommon and complex operations in each of the above areas.
- Clinical knowledge, including epidemiology, anatomy, physiology, clinical presentation, and pathology (including neoplasia).
- Knowledge of the scientific foundations, including wound healing, infection, fluid management, shock and resuscitation, immunology, antibiotic usage, metabolism, and use of enteral and parenteral nutrition.
- Experience and skill in the following areas: clinical evaluation and management, or stabilization and referral, of patients with surgical diseases; management of preoperative, operative and post-operative care; management of comorbidities and complications; and knowledge of appropriate use and interpretation of radiologic and other diagnostic imaging.

3. The following disciplines have training programs related to, but separate from, general surgery. As the primary surgical practitioner in many circumstances, the certified general surgeon is required to be familiar with diseases and operative techniques in these areas. The certified general surgeon will have experience during training that will allow for diagnosis and management of a select group of conditions in these areas. **However, comprehensive knowledge and management of conditions in these areas generally requires additional training.**
 - Organ Transplantation
 - Pediatric Surgery
 - Thoracic surgery
 - Vascular Surgery
4. In addition, the certified general surgeon is expected to be able to recognize and provide early management and appropriate referral for urgent and emergent problems in the surgical fields of:
 - Gynecology
 - Urology
 - Neurosurgery
 - Orthopaedics and Hand Surgery
5. The certified general surgeon is also expected to have knowledge and skills in the management and team-based interdisciplinary care of the following specific patient groups:
 - Terminally ill patients, to include palliative care and management of pain, weight loss, and cachexia in patients with malignant and chronic conditions.
 - Morbidly obese patients, to include metabolic derangements, weight-loss surgery and the counseling of patients and families.
 - Geriatric surgical patients, to include operative and nonoperative care, management of co-morbid chronic diseases, and the counseling of patients and families.
 - Culturally diverse groups of patients.

E. Website Resources

The ABS website, www.absurgery.org, offers many resources for individuals interested in ABS certification. Potential applicants are encouraged to familiar-

ize themselves with the website. Applicants and candidates may use the website to update their personal information, submit an online application, check their application's status and view their recent examination history.

In addition, the following policies are posted on the website. They are reviewed regularly and supersede any previous versions.

- *Credit for Foreign Graduate Medical Education*
- *Ethics and Professionalism*
- *Examination of Persons with Disabilities*
- *Leave Policy*
- *Limitation on Number of Residency Programs*
- *Military Activation*
- *Privacy Policy*
- *Reconsideration and Appeals*
- *Regaining Admissibility to General Surgery Examinations*
- *Reporting of Status*
- *Representation of Certification Status*
- *Revocation of Certificates*
- *Substance Abuse*

II. REQUIREMENTS FOR CERTIFICATION

A. General Requirements

Applicants for certification in surgery must meet these general requirements:

- **Have demonstrated to the satisfaction of the program director** of an accredited graduate medical education program in general surgery that they have attained the level of qualifications required by the ABS. All phases of the graduate educational process must be completed in a manner satisfactory to the ABS.
- **Have an ethical, professional, and moral status** acceptable to the ABS.
- **Be actively engaged in the practice of general surgery** as indicated by holding admitting privileges to a surgical service in an accredited health care organization, or be currently engaged in pursuing additional graduate education in a component of surgery or other recognized surgical specialty. An exception to this requirement is active military duty.
- **Hold a currently registered full and unrestricted license to practice medicine** in the United States or Canada within six months after completion of general surgery residency. A full and unrestricted license is not required for the Qualifying Examination if it is taken within six months following completion of residency. However, if successful on the QE, candidates must have a full and unrestricted license to take the Certifying Examination regardless of when it is taken. Temporary, limited, educational or institutional medical licenses will not be accepted, even if the candidate is in a fellowship.

An applicant must immediately inform the ABS of any conditions or restrictions in force on any active medical license he or she holds in any state or province. When there is a restriction or condition in force on any of the applicant's medical licenses, the Credentials Committee of the ABS will determine whether the applicant satisfies the above licensure requirement.

B. Undergraduate Medical Education

Applicants must have graduated from an accredited school of allopathic or osteopathic medicine in the United States or Canada. Graduates of schools of medicine in countries other than the United States or Canada must present evidence of certification by the Educational Commission for Foreign Medical Graduates (ECFMG). *(See also II-G-2. Credit for Foreign Graduate Education.)*

C. Graduate Surgical Education

1. General Information

The purpose of graduate education in surgery is to provide the opportunity to acquire a broad understanding of human biology as it relates to disorders of a surgical nature, and the technical knowledge and skills appropriate to be applied by a specialist in surgery. This goal can best be attained by means of a progressively graded curriculum of study and clinical experience under the guidance and supervision of senior surgeons, which provides progression through succeeding stages of responsibility for patient care up to the final stage of complete management. Major operative experience and independent decision making at the final stage of the program are essential components of surgical education. The ABS will not accept into the certification process anyone who has not had such an experience in the specialty of surgery, as previously defined in section I-D, regardless of the number of years spent in educational programs.

The graduate educational requirements set forth on these pages are considered to be the minimal requirements of the ABS and should not be interpreted to be restrictive in nature. The time required for the total educational process should be sufficient to provide adequate clinical experience for the development of sound surgical judgment and adequate technical skill. These requirements do not preclude additional desirable educational experience, and program directors are encouraged to retain residents in a program as long as is required to achieve the necessary level of qualifications.

The integration of basic sciences with clinical experience is considered to be superior to formal courses in such subjects. Accordingly, while recognizing the value of formal courses in the study of surgery and the basic sciences at approved graduate schools of medicine, the ABS will not accept such courses in lieu of any part of the required clinical years of surgical education.

The ABS may at its discretion require that a member of the ABS or a designated diplomate observe and report upon the clinical performance of an applicant before establishing admissibility to examination, or before awarding or renewing certification.

While residency programs may develop their own vacation, illness and leave policies for residents, one year of approved residency toward ABS requirements must be 52 weeks in duration and include at least 48 weeks of full-time surgical experience. All vacation and leave time must be accurately reported on the application for certification.

2. Specific Requirements

To be accepted into the certification process, applicants must have completed the following:

- **A minimum of five years of *progressive residency education*** satisfactorily following graduation from medical school in a program in general surgery accredited by the Accreditation Council for Graduate Medical Education (ACGME) or Royal College of Physicians and Surgeons of Canada (RCPSC).

Repetition of one clinical level may not replace another year in the sequence of training, e.g., completing two years at the PGY-2 level does not permit promotion to PGY-4; a categorical PGY-3 year must be completed.

Individuals must apply for certification within three years of completing such a program to retain their admissibility to the certification process. A list of U.S. programs accredited by the ACGME may be found at www.acgme.org.

- **All phases of graduate education in general surgery in an accredited general surgery program.**

Experience obtained in accredited programs in other recognized specialties, although containing some exposure to surgery, is not acceptable.

In addition, a flexible or transitional first year will not be credited toward PGY-1 training unless it is accomplished in an institution with an accredited program in surgery and at least six months of the year is spent in surgical disciplines.

- **Sixty months of residency training at no more than three residency programs.** This limit applies regardless of whether an applicant completed clinical years as a non-designated preliminary or categorical resident. Individuals who completed their training at more than three programs will be required to repeat one or more years of training to comply with this limit.

For applicants who trained at more than one program, documentation of satisfactory completion of years in prior programs from the appropriate program directors must be submitted. When credit is granted for prior training outside the U.S. or Canada, it will be counted as one institution.

- **No fewer than 48 weeks of full-time experience in each residency year.** This is required regardless of the amount of operative experience obtained.

- **At least 54 months of clinical surgical experience with progressively increasing levels of responsibility** over the five years in an accredited surgery program, including **no fewer than 42 months devoted to the content areas of general surgery** as previously defined in section I-D.
- **The programs *Advanced Cardiovascular Life Support (ACLS)*, *Advanced Trauma Life Support® (ATLS®)* and *Fundamentals of Laparoscopic Surgery (FLS)***. Applicants are not required to be currently certified in these programs; they must only provide documentation of prior successful completion.
- **No more than six months during junior years assigned to non-clinical or non-surgical disciplines** that are supportive of the needs of the individual resident and appropriate to the overall goals of the general surgery training program. Experience in surgical pathology and endoscopy is considered to be clinical surgery, but obstetrics and ophthalmology are not. No more than a total of 12 months during junior years may be allocated to any one surgical specialty other than general surgery.
- **The entire chief resident experience in either the content areas of general surgery, as defined in section I-D, or thoracic surgery**, with no more than four months devoted to any one component. All resident rotations at the PGY-4 and PGY-5 levels should involve substantive major operative experience and independent decision making.
- **Acting in the capacity of chief resident in general surgery for a 12-month period**, with the majority of the 12 months served in the final year. The term “chief resident” indicates that a resident has assumed ultimate clinical responsibility for patient care under the supervision of the teaching staff and is the most senior resident involved with the direct care of the patient. A portion of the chief residency may be served in the next to the last year, provided it is no earlier than the fourth clinical year and has been approved by the Residency Review Committee for Surgery (RRC-Surgery) followed by notification to the ABS. (*Special requirements apply to early specialization in vascular surgery and thoracic surgery; see www.absurgery.org.*)
- **The final two residency years in the same program**, unless prior approval for a different arrangement has been granted by the ABS.

D. Operative Experience

Applicants for examination must have been the operating surgeon for a minimum of **750 operative procedures in five years**, including at least **150 operative procedures in the chief resident year**. The procedures must include operative experience in each of the content areas listed in the definition of general surgery set forth in section I-D.

A minimum of 25 cases is required in the area of surgical critical care patient management, with at least one case in each of the area's seven categories.

Applicants must submit a report that tabulates their operative experience during residency, including the number of patients with multiple organ trauma where a major general surgical operation was not required. Applicants must also indicate their level of responsibility (e.g., surgeon chief year, surgeon junior years, teaching assistant, first assistant) for the procedures listed.

Applicants may claim credit as "surgeon chief year" or "surgeon junior years" only when they have actively participated in making or confirming the diagnosis, selecting the appropriate operative plan, and administering preoperative and postoperative care. Additionally, they must have personally performed either the entire operative procedure or the critical parts thereof and participated in postoperative follow-up. All of the above must be accomplished under appropriate supervision.

When previous personal operative experience justifies a teaching role, residents may act as teaching assistants and list such cases during the fourth and fifth year only. Applicants may claim credit as teaching assistant only when they have been present and scrubbed and acted as assistant to guide a more junior trainee through the procedure. **Applicants may count up to 50 cases as teaching assistant toward the 750 operative case total; however these cases may not count toward the 150 chief year cases.**

Applicants may not claim credit both as surgeon (surgeon chief or surgeon junior) **and** teaching assistant.

E. Leave Policy

1. Leave During a Standard Five-Year Residency

For documented medical problems or maternity leave, the ABS will accept 46 weeks of training in **one** of the first three years of residency and 46 weeks of training in **one** of the last two years, for a total of 142 weeks in the first three years and 94 weeks in the last two years. Unused vacation or leave time cannot be applied to reduce the amount of full-time experi-

ence required per year without written permission from the ABS. Such requests may only be made by the program director.

2. Six-Year Option

If permitted by the residency program, the five clinical years of residency training may be completed over six academic years. All training must be completed at a single program with advance approval from the ABS. Forty-eight weeks of training are required in each clinical year and all individual rotations must be full-time. The first 12 months of clinical training would be counted as PGY-1, the second 12 months as PGY-2, and so forth. No block of clinical training may be shorter than one month (four weeks).

Under this option, a resident may take up to 12 months off during training, excluding the chief year. The resident would first work with his or her program to determine an appropriate leave period or schedule. The program would then request approval for this plan from the ABS. The chief year of residency must be completed in 12 consecutive months of training with the usual vacation/time off requirements.

Use of the six-year option is solely at the program's discretion, and contingent on advance approval from the ABS. The option may be used for any purpose approved by the residency program, including but not limited to family issues, visa issues, medical problems, maternity leave, external commitments, volunteerism, pursuit of outside interests, educational opportunities, etc.

F. Ethics and Professionalism

The ABS believes that certification in surgery carries an obligation for ethical behavior and professionalism in all conduct. The exhibition of unethical behavior or a lack of professionalism by an applicant or diplomate may prevent the certification of an applicant or may result in the suspension or revocation of certification. All such determinations shall be at the sole discretion of the ABS.

Unethical and unprofessional behavior is denoted by any dishonest behavior, including cheating; lying; falsifying information; misrepresenting one's educational background, certification status and/or professional experience; and failure to report misconduct. The American Board of Surgery has adopted a "zero tolerance" policy toward these behaviors, and individuals caught exhibiting such behaviors risk being permanently barred from certification, reported to state medical boards, and/or legally prosecuted. (*See also III-D-2. Examination Irregularities.*)

G. Additional Considerations

1. Military Service

Credit will not be granted toward the requirements of the ABS for service in the U.S. Armed Forces, the U.S. Public Health Service, the National Institutes of Health or other governmental agencies unless the service was as a duly appointed resident in an accredited program in surgery.

2. Credit for Foreign Graduate Education

The ABS does not grant credit directly to residents for surgical education outside the U.S. or Canada. The ABS will consider granting partial credit for foreign graduate medical education to a resident in a U.S. general surgery residency program accredited by the ACGME, but **only upon request of the program director**. Preliminary evaluations will not be provided before enrollment in a residency program, either to a resident or program director.

All requests for credit and related inquiries must come from the program director and must be sent in writing **by letter**, not e-mail. Program directors will be notified of credit decisions by letter from the ABS executive director.

The program director is the primary judge of the resident's proficiency level and should make the request for credit only after having observed the individual as a junior resident for approximately nine months to ascertain that clinical performance is consistent with the level of credit to be requested. Requests for credit from the program director must be accompanied by documentation of the following:

- Satisfactory completion of foreign medical school and foreign residency training
- Specialty certification in the foreign venue, if achieved
- Chronological listing of former foreign and U.S. practice after specialty training
- Chronological listing of all U.S. training, with specific description of accreditation status of training program and whether or not resident occupied an accredited or supernumerary (above accredited limit) position in program
- Attestation by program director of satisfactory completion of all U.S. or Canadian surgical resident training years for which credit is sought
- All scores on the ABS In-Training Examination (ABSITE)

Residents must take the ABSITE before any credit may be requested. The resident's scores on the ABSITE should be consonant with the level of credit requested.

Program directors who wish to advance residents to senior or chief levels (PGY-4 or PGY-5) must have obtained ABS approval prior to beginning the PGY-4 year; otherwise senior level credit for these years will be denied. Requests for credit should only be submitted once all required documentation is available.

Credit for foreign training may be granted in lieu of the first or second clinical years of residency, and rarely the third. Credit is never given for the fourth or fifth clinical years, which must be completed satisfactorily in an accredited U.S. program. If a resident is felt to be a candidate for credit, he or she should normally begin residency at the PGY-2 or PGY-3 level so that the appropriate level of clinical skills can be assessed.

Typically one year of credit will be granted for three or more years of foreign training. Two years of credit will be granted for full surgical training plus board certification or its equivalent in the foreign venue, if the training is similar in length and in the breadth of experience obtained. **The granting of credit is not guaranteed.** If the resident moves to another program, the credit is **not transferable** and must be requested by the resident's new program director after a new period of evaluation.

Canadian Residents

Applicants who trained in Canada must have completed all of the requirements in a Canadian surgery program accredited by the RCPSC or in combination with a U.S. surgery program accredited by the ACGME. No credit for surgical education outside the U.S. and Canada will be granted to applicants who complete a Canadian program. Applicants from Canadian programs must comply with ABS requirements for certification.

(See the Credit for Foreign Graduate Medical Education policy available at www.absurgery.org for further details.)

3. Information for Program Directors

When making advancement determinations, program directors are cautioned against appointing residents to advanced levels without first ensuring that their previous training is in accordance with ABS certification requirements. Program directors should contact the ABS prior to making a promotion decision if there is any question of a resident's completed training not meeting ABS requirements.

At the end of each academic year, the ABS requires that program directors verify the satisfactory completion of the preceding year of training for each resident in their program, using the resident roster information submitted to the ABS. For residents who have transferred into their program, program directors must obtain written verification of satisfactory completion for all prior years of graduate medical education. Upon application for certification, residents who have transferred programs must provide this verification to the ABS.

In addition to its own requirements, the ABS also adheres to ACGME program requirements for residency training in general surgery. These include that program directors must obtain the approval of the RRC-Surgery in the following situations: (1) for resident assignment of six months or more at a participating non-integrated site; or (2) if chief resident rotations are carried out prior to the last 12 months of residency training. Documentation of such approval or prior ABS approval should accompany the individual's application.

As the RRC-Surgery does not review the adequacy of surgical education outside the United States, the ABS will not normally accept any rotations outside the U.S. or Canada toward its requirements. If program directors wish to credit training abroad toward ABS requirements, they must fully justify the reasons for it and receive ABS approval for such training in advance.

4. Reconsideration and Appeals

The ABS may deny or grant an applicant or candidate the privilege of examination whenever the facts in the case are deemed by the ABS to so warrant.

Applicants and candidates may request reconsideration and appeal as outlined in the ABS' published policy. A copy of the *Reconsideration and Appeals* policy is available from the ABS office or website, www.absurgery.org. A request for reconsideration, the first step, must be made in writing to the ABS office within 90 days of receipt of notice of the action in question.

III. EXAMINATIONS IN SURGERY

All ABS examinations are developed by committees consisting of ABS directors and experienced diplomates nominated by directors to serve as examination consultants. All are required to hold current, time-limited certificates. Neither directors nor consultants receive any remuneration for their services. All ABS examinations are protected by federal copyright (*see III-D-2. Examination Irregularities*).

A. The In-Training Examination

The ABS offers annually to U.S. residency programs the In-Training Examination, a multiple-choice examination designed to measure the progress attained by residents in their knowledge of the basic sciences and the management of clinical problems related to surgery. It is offered in two versions: a junior-level version for PGY 1-2 with an emphasis on basic science, diagnosis and evaluation; and a senior-level version for PGY 3-5 focusing primarily on clinical management. As of 2011, the exam is administered to all programs in an online format.

The ABSITE is solely meant to be used by program directors as an evaluation instrument in assessing residents' progress and results of the examination are released to program directors only. The ABS will not release score reports to residents. The examination is not available to residents on an individual basis and is not required by the ABS as part of the certification process.

The ABS reserves the right to withhold participation in the examination by an institution where in prior years there were cases of improper use, unacceptable test administration, or irregular behavior by residents taking the examination.

B. The Qualifying Examination

1. General Information

The Qualifying Examination is an eight-hour, computer-based examination offered once annually. The examination consists of multiple-choice questions designed to evaluate a candidate's knowledge of general surgical principles and the basic sciences applicable to surgery. Information regarding exam dates and fees, as well as an exam content outline, is available at www.absurgery.org.

Examination results are mailed and posted on the website approximately two to three weeks after the examination. Examinees' results are also reported to the director of the program in which they completed their final year of residency.

2. Application Process

Individuals who believe they meet the requirements for certification in surgery may apply to the ABS for admission to the certification process. All training must be completed by July 1 for the applicant to be eligible for that year's Qualifying Examination. Application requirements and the online application process are available from the ABS website, www.absurgery.org.

The individual who served as the applicant's program director during residency must certify that all information supplied by the applicant is accurate.

An application will not be approved unless:

- Every rotation completed during residency training is listed separately and consecutively.
- All vacation and leave time is reported accurately.
- Documentation of completion of ACLS, ATLS and FLS is provided.
- Cases are listed for patient care/non-operative trauma, in addition to the 25 cases required in surgical critical care patient management.
- For applicants who trained in more than one program, documentation of satisfactory completion for all years in each program is provided.
- For international medical graduates, a copy of their ECFMG certificate is provided.

Applicants should keep a copy of all submitted information as the ABS will not furnish copies. Applicants are also strongly advised to maintain a current mailing address with the ABS during the application process to avoid unnecessary delays.

Note that the acceptability of an applicant does not depend solely upon completion of an approved program of education, but also upon information received by the ABS regarding professional maturity, surgical judgment, technical capabilities and ethical standing.

3. Admissibility

An applicant will be considered admissible to the Qualifying Examination only when all requirements of the ABS currently in force at the time of application have been satisfactorily fulfilled, including acceptable operative experience and the attestation of the program director regarding the applicant's surgical skills and ethics and professionalism.

In addition:

- Applicants who desire certification **must apply for certification within three academic years** after completion of residency.
- Once an application is approved, the applicant **must take the Qualifying Examination for the first time** in the year of application approval or the year following.

Applicants who exceed either of the above time limits will lose admissibility to the ABS certification process and must fulfill a readmissibility pathway if they still wish to seek certification.

4. Examination Opportunities

Once an application is approved, the applicant has a maximum of **five opportunities within a five-year period** to pass the QE; if unsuccessful, a new application is not required during this period. If the applicant chooses not to take the examination in a given year, this is considered a lost opportunity as **the five-year limit is absolute**. Applicants who fail to pass within the five-year period may regain admissibility through the readmissibility pathways described below.

5. Readmissibility

Individuals who are no longer admissible to the ABS certification process may regain admissibility through the following pathways.

Standard Pathway

The individual must complete an additional year (12 months) of structured education in surgery in an ACGME-accredited general surgery residency program, in which the program director has agreed to provide the applicant with structured teaching that meets ABS guidelines. The structured educational program must be submitted to the ABS in advance for approval and must be a full-time activity. The program director is required to submit quarterly summaries to the ABS of the applicant's progress. Upon completion of the year, the program director must provide written attestation that the individual has successfully completed all requirements. He or she must then complete an application for readmissibility and provide documentation of a current full and unrestricted medical license.

Alternative Pathway

The individual may pursue an alternative educational pathway to acquire and demonstrate adequate surgical knowledge, which may be accomplished at a

pace determined by the applicant. The initial readmissibility application requires evidence of continuing medical education activity, completion of the American College of Surgeons' Surgical Education and Self-Assessment Program (SESAP), reference letters and an operative experience report. Upon approval of the application, the applicant must take and pass two secure examinations: one derived from the ABSITE and another derived from the two latest versions of SESAP. Please refer to *Regaining Admissibility to General Surgery Examinations* at www.absurgery.org for complete details.

Upon successful completion of either of the above pathways, the individual will again be admissible to the QE for five opportunities within five years. If the individual is not successful in satisfactorily completing a readmissibility pathway or passing the QE during the readmissibility period, he or she must reenter formal residency training for PGY-4 and PGY-5 level training in a surgery program accredited by the ACGME or RCPSC to regain admissibility to a third five-year period.

Time Limitations

If an individual has not actively pursued admissibility or readmissibility to the certification process within 10 years after completion of residency, he or she will be required to reenter formal residency training for PGY-4 and PGY-5 level training in a surgery program accredited by the ACGME or RCPSC to regain admissibility to the certification process.

C. The Certifying Examination

1. General Information

The Certifying Examination is an oral examination consisting of three 30-minute sessions conducted by teams of two examiners that evaluates a candidate's clinical skills in organizing the diagnostic evaluation of common surgical problems and determining appropriate therapy. The examination focuses on the application of basic knowledge to clinical problems; evaluation of surgical judgment and decision making; management of complex complications; and assessment of technical knowledge.

The CE is administered several times a year in various major U.S. cities. The examinations are conducted by ABS directors and by associate examiners who are experienced ABS diplomates in the local or regional medical community. All examiners are active in the practice of surgery and hold current,

time-limited certificates. The ABS makes every effort to avoid conflicts of interest between candidates and their examiners.

Please refer to www.absurgery.org for further information about the CE, including exam dates and fees. Examination results are generally posted on the ABS website and mailed the day after the final day of examination. Examinees' results are also reported to the director of the program in which they completed their final year of residency.

2. Admissibility

To be admissible to the CE, a candidate must have successfully completed the Qualifying Examination and hold a **full and unrestricted license** to practice medicine in the United States or Canada and provide evidence of this to the ABS office. The license must be valid through the date of the examination.

Temporary, limited, educational or institutional medical licenses will not be accepted, even if a candidate is currently in a fellowship.

3. Examination Opportunities

Upon successful completion of the Qualifying Examination, candidates are offered **five opportunities within a five-year period** to pass the Certifying Examination. **Both of these limits are absolute;** exceptions will only be made for active duty military service outside the United States.

Candidates may take the CE **no more than twice in an academic year**. If a specific CE site has limited availability, priority for assignment to that site will be given to candidates who have yet to take a CE in that academic year.

Candidates for certification are encouraged not to unduly delay taking the CE, as such delays may adversely affect performance. Candidates are discouraged from taking the CE more than once in an academic year as the examination evaluates a candidate's clinical knowledge and judgment, which in general do not significantly improve over the course of only a few months.

Candidates who are not successful in the five opportunities taken during the five-year period must fulfill a readmissibility pathway if they still wish to seek certification. This process may begin as soon as the five opportunities are exhausted by the candidate.

4. Readmissibility

Individuals may regain admissibility to the CE by the pathways described on the next page.

Standard Pathway

The individual must complete an additional year (12 months) of structured education in surgery in an ACGME-approved surgical residency program, in which the program director has agreed to provide the applicant with structured teaching that meets ABS guidelines. The structured educational program must be submitted to the ABS in advance for approval and must be a full-time activity. The program director is required to submit quarterly summaries to the ABS of the applicant's progress. Upon completion of the year, the program director must provide written attestation that the individual has successfully completed all requirements.

Alternative Pathway

The individual may pursue an alternative educational pathway to acquire and demonstrate adequate surgical knowledge, which may be accomplished at a pace determined by the applicant. The initial readmissibility application requires evidence of continuing medical education activity, completion of SESAP, reference letters and an operative experience report. Upon approval of the application, the applicant must take and pass three secure examinations: one derived from the ABSITE; another derived the two latest versions of SESAP; and the General Surgery Qualifying Examination. Please refer to *Regaining Admissibility to General Surgery Examinations* at www.absurgery.org for complete details.

Upon successful completion of either of the above pathways, the individual will again be admissible to the CE for five opportunities within five years. If the individual is not successful in satisfactorily completing a readmissibility pathway or achieving certification during the readmissibility period, he or she must reenter formal residency training for PGY-4 and PGY-5 level training in a surgery program accredited by the ACGME or RCPSC to regain admissibility to a third five-year period.

D. Special Circumstances

1. Persons with Disabilities

The American Board of Surgery complies with the Americans with Disabilities Act by making a reasonable effort to provide modifications in its examination process to applicants with documented disabilities. These modifications are appropriate for such disabilities but do not alter the measurement of skills or knowledge that the examination process is intended to

test. The ABS has adopted a specific policy and procedure regarding the examination of such applicants, which is available at www.absurgery.org. Any disability that an applicant believes requires modification of the administration of an examination must be identified and documented by the applicant in accordance with this policy. All materials submitted to the ABS documenting the disability must be received no later than the published application deadline for the examination in question. Requests for exam accommodations and documentation received after this date may not be processed in time.

2. Examination Irregularities and Unethical Behavior

Examination irregularities, i.e., cheating in any form, or other unethical behavior by an applicant or diplomate may result in the barring of the individual from examination on a temporary or permanent basis, the denial or revocation of a certificate, and/or other appropriate actions, up to and including legal prosecution. Determination of sanctions for irregular or unethical behavior will be at the sole discretion of the ABS.

The ABS considers unethical behavior to include the disclosure, publication, reproduction or transmission of ABS examinations, in whole or in part, in any form or by any means, verbal or written, electronic or mechanical, for any purposes. This also extends to sharing examination information or discussing an examination while still in progress. Unethical behavior also includes the possession, reproduction or disclosure of materials or information, including examination questions or answers or specific information regarding the content of the examination, before, during or after the examination. This definition specifically includes the recall and reconstruction of examination questions by any means and such efforts may violate federal copyright law. All ABS examinations are copyrighted and protected by law; the ABS will prosecute copyright violations to the full extent provided by law and seek monetary damages for any loss of examination materials. (*See www.absurgery.org for complete ABS Ethics and Professionalism Policy.*)

3. Substance Abuse

Applicants with a history of substance abuse will not be admitted to any examination unless they present evidence satisfactory to the ABS that they have successfully completed the program of treatment prescribed for their condition. The ABS must additionally be satisfied that they are currently free of substance abuse.

IV. ISSUANCE OF CERTIFICATES

A candidate who has met all requirements and successfully completed the Qualifying and Certifying Examinations of the ABS will be deemed certified in surgery and issued a certificate by the ABS, signed by its officers, attesting to these qualifications.

It is the current policy of the ABS that all certificates issued on or after January 1, 1976 are valid only for a period of ten years, from the date of issuance through June 30 of the year of expiration. Certificates issued prior to January 1, 1976 are valid indefinitely.

Diplomates who certify or recertify after July 1, 2005 must participate in the ABS Maintenance of Certification Program (MOC) to maintain their certificate (*see section IV-C*). The ABS reserves the right to change the duration of its certificates or the requirements of MOC at any time.

A. Reporting of Status

The ABS considers the personal information and examination record of an applicant or diplomate to be private and confidential. When an inquiry is received regarding an individual's status with the ABS, a general statement is provided indicating the person's current situation as pertains to ABS certification, along with his or her certification history.

The ABS will report an individual as having one of three statuses: *Certified*, *Not Certified* or *In the Examination Process*. In certain cases, one of the following descriptions may also be reported: *Clinically Inactive*, *Suspended* or *Revoked*. Please refer to the *Reporting of Status* policy on the ABS website for definitions of the above terms. An individual's status with the ABS may be verified through the ABS website, www.absurgery.org.

The ABS does not use or condone such terms as "board eligible" or "board qualified," and will only indicate whether an individual is admissible to ABS examinations (*In the Examination Process*). Additionally, individuals may only describe themselves as certified by the ABS or as an ABS diplomate when they hold a **current** ABS certificate. See *Representation of Certification Status* at www.absurgery.org for more information.

The ABS supplies biographical and demographic data on diplomates to the American Board of Medical Specialties for its *Directory of Certified Medical Specialists*, which is available in print and online at www.abms.org. Upon certification, diplomates will

be contacted by the ABMS and asked to specify which information they would like to appear in the directory. Diplomates will have their listings retained in the directory only if they maintain their certification according to the ABS MOC Program.

B. Sanction of Certificate

Certification by the American Board of Surgery may be subject to sanction such as revocation or suspension at any time that the directors shall determine, in their sole judgment, that the diplomate holding the certification was in some respect not properly qualified to receive it or is no longer properly qualified to retain it.

The directors of the ABS may consider sanction for just and sufficient reason, including, but not limited to, any of the following:

- The diplomate did not possess the necessary qualifications nor meet the requirements to receive certification at the time it was issued; falsified any part of the application or other required documentation; participated in any form of examination irregularities; or made any material misstatement or omission to the ABS, whether or not the ABS knew of such deficiencies at the time.
- The diplomate misrepresented his or her status with regard to board certification, including any misstatement of fact about being board certified in any specialty or subspecialty.
- The diplomate engaged in conduct resulting in a revocation, suspension, qualification or other limitation of his or her license to practice medicine in any jurisdiction and/or failed to inform the ABS of the license restriction.
- The diplomate engaged in conduct resulting in the expulsion, suspension, disqualification or other limitation from membership in a local, regional, national or other organization of his or her professional peers.
- The diplomate engaged in conduct resulting in revocation, suspension or other limitation on his or her privileges to practice surgery in a health care organization.
- The diplomate failed to respond to inquiries from the ABS regarding his or her credentials, or to participate in investigations conducted by the board.
- The diplomate failed to provide an acceptable level of care or demonstrate sufficient competence and technical proficiency in the treatment of patients.

- The diplomate failed to maintain ethical, professional and moral standards acceptable to the ABS.

The holder of a revoked or suspended certificate will be given written notice of the reasons for its sanction by express letter carrier (e.g., FedEx) to the last address that the holder has provided to the ABS. Sanction is final upon mailing of the notification.

Upon revocation of certification, the holder's name shall be removed from the list of certified surgeons and the holder is required to return the certificate to the ABS office.

Individuals may appeal the decision to revoke or suspend a certificate by complying with the ABS *Reconsideration and Appeals* policy, available from the ABS office or website (www.absurgery.org). A request for reconsideration, the first step, must be made in writing to the ABS office within 90 days of receipt of notice from the ABS of the action in question.

Should the circumstances that justified revocation of certification be corrected, the directors of the ABS at their sole discretion may reinstate the certificate after appropriate review of the individual's licensure and performance using the same standards as applied to applicants for certification, and following fulfillment by the individual of requirements for certification or recertification as previously determined by the ABS.

Requirements for certificate reinstatement will be determined by the ABS on a case-by-case basis in parallel with the type and severity of the original infraction, up to and including complete repetition of the initial certification process. Individuals who have had their certification revoked or suspended and then restored, regardless of their initial certification status or prior dates of certification, will be required to take and pass the next recertification examination to reinstate their certification. Upon passing the examination, they will be awarded a new, time-limited certificate and enrolled in the ABS MOC Program.

C. Maintenance of Certification

Maintenance of Certification is a program of continuous professional development created by the ABS in conjunction with the ABMS and its 23 other member boards. MOC, which replaces the ABS' previous recertification requirements, is intended to document to the public and the health care community the ongoing commitment of diplomates to lifelong learning and quality patient care.

MOC consists of four parts to be fulfilled over the 10-year certification period: (1) professional standing; (2) lifelong learning and self-assessment; (3) cognitive expertise; and (4) evaluation of performance in practice. Diplomates who certify or recertify after July 1, 2005 must comply with the requirements of the ABS MOC Program to maintain their certificate. Please refer to www.absurgery.org for the current requirements.

The ABS considers MOC to be voluntary in the same manner as original certification. MOC is also offered to diplomates holding ABS certificates in other specialties, with comparable requirements.

Surgeons who recertify prior to the expiration date of their certificate will receive a new certificate with an expiration date extending from the expiration date of the previous certificate, not the date of recertification.

To assure receipt of materials pertaining to MOC, diplomates are strongly encouraged to notify the ABS promptly of any changes of address.

D. Certification in Surgical Specialties

The ABS has been authorized by the ABMS to award certification to individuals who have pursued specialized training and meet defined requirements in certain disciplines related to the specialty of surgery. These disciplines currently include vascular surgery, pediatric surgery, surgical critical care (SCC), surgery of the hand, and hospice and palliative medicine.

In general, those seeking specialty certification by the ABS must fulfill the following requirements:

- Be currently certified by the ABS in general surgery (*see next page for exceptions*).
- Possess a full and unrestricted license to practice medicine in the U.S. or Canada.
- Have completed the required training in the discipline.
- Demonstrate operative experience and/or patient care data acceptable to the ABS.
- Show evidence of dedication to the discipline as specified by the ABS.
- Receive favorable endorsement by the director of the training program in the particular discipline.
- Successfully complete the prescribed examinations.

Individuals interested in certification in these specialties should refer to www.absurgery.org for further information.

Primary Certification in Vascular Surgery

A primary certificate in vascular surgery took effect July 1, 2006. Individuals who complete an ACGME-accredited, integrated vascular surgery training program may apply directly for vascular surgery certification without completing a general surgery residency or obtaining general surgery certification. Individuals who complete a non-integrated vascular surgery fellowship accredited by the ACGME or RCPS(C) or an early specialization program must complete a full general surgery residency, but prior certification in general surgery is not required for vascular surgery certification if the general surgery training was completed after July 1, 2006.

Applicants who complete a non-integrated program and wish to pursue certification in both general and vascular surgery must first apply for and successfully complete the General Surgery Qualifying Examination before entering the vascular surgery certification process. Upon passing this examination, applicants may then pursue certification in both disciplines in whichever order they prefer.

Applicants for vascular surgery certification who choose not to apply or who are ineligible for general surgery certification will be required to successfully complete the Surgical Principles Examination (SPE) before being admitted to the vascular surgery certification process. Applicants who elect to take the SPE permanently forfeit, if eligible, their admissibility to the General Surgery Qualifying Examination.

Options for SCC Certification

Individuals who have completed an ACGME-accredited training program in SCC or anesthesiology critical care after three years of progressive general surgery residency may take the SCC Certifying Examination while still in residency. A full and unrestricted license is not required at that time. However, if successful on the examination, they will not be considered certified in SCC until they become certified in surgery. When entering the SCC program, applicants must have a guaranteed categorical residency position in an accredited surgery program available to them upon completion.

Diplomates of other ABMS surgical boards are eligible for SCC certification by the ABS upon completion of an accredited SCC or anesthesiology critical care training program, providing their primary certifying board supports their application for SCC certification.

Joint Training in Thoracic Surgery

Individuals may pursue a pathway leading to certification in both general surgery and thoracic surgery to be accomplished in a joint training program accredited by the ACGME of four years of general surgery followed by three years of thoracic surgery at the same institution. PGY-4 and PGY-5 are used as transitional years that fulfill the required surgery curriculum and simultaneously begin thoracic surgical training. For further information on this pathway, see www.absurgery.org.

V. ABOUT THE ABS

A. Nominating Organizations

The American Board of Surgery is composed of a board of directors elected to single six-year terms from among nominees provided by national and regional surgical societies, known as nominating organizations. In addition, three directors are elected through an at-large process. The ABS also has one public member, elected by open nomination.

Founding Organizations

American College of Surgeons
American Medical Association
American Surgical Association

Regional Surgical Organizations

Central Surgical Association
New England Surgical Society
Pacific Coast Surgical Association
Southeastern Surgical Congress
Southern Surgical Association
Southwestern Surgical Congress
Western Surgical Association

Academic/Research Organizations

Association for Academic Surgery
Society of University Surgeons

Specialty Surgical Organizations

American Association for the Surgery of Trauma
American Pediatric Surgical Association
American Society of Transplant Surgeons
Society of American Gastrointestinal Endoscopic Surgeons
Society for Surgery of the Alimentary Tract
Society of Surgical Oncology
Society for Vascular Surgery

Program Director Associations

Association of Pediatric Surgery Training Program Directors
Association of Program Directors in Surgery
Association of Program Directors in Vascular Surgery

Other ABMS Surgical Boards

American Board of Colon and Rectal Surgery
American Board of Plastic Surgery
American Board of Thoracic Surgery

B. Officers and Directors

The officers of the ABS include a chair and vice chair elected by the directors from among themselves. The vice chair is elected for a one-year term and then serves the succeeding year as chair. A third elected officer, the secretary-treasurer, also serves as executive director and is not necessarily chosen from among the directors, although prior experience in some capacity with the ABS as a director, exam consultant or associate examiner is highly desirable.

2010-2011 Officers

E. Christopher Ellison, M.D., *Chair*

Stanley W. Ashley, M.D., *Vice Chair*

Frank R. Lewis Jr., M.D., *Secretary-Treasurer*

2010-2011 Directors

Stanley W. Ashley, M.D.

Karen R. Borman, M.D.

L. D. Britt, M.D.

Jo Buyske, M.D.

Joseph B. Cofer, M.D.

Thomas H. Cogbill, M.D.

John F. Eidt, M.D.

E. Christopher Ellison, M.D.

Stephen R. T. Evans, M.D.

B. Mark Evers, M.D.

John B. Hanks, M.D.

Douglas W. Hanto, M.D.

Ronald B. Hirschl, M.D.

John G. Hunter, M.D.

Lenworth M. Jacobs Jr., M.B.B.S.

Nathalie M. Johnson, M.D.

Gregory J. Jurkovich, M.D.

V. Suzanne Klimberg, M.D.

Frank R. Lewis Jr., M.D.

David M. Mahvi, M.D.

David W. Mercer, M.D.

J. Wayne Meredith, M.D.

Fabrizio Michelassi, M.D.

Joseph L. Mills, M.D.

Leigh A. Neumayer, M.D.

John R. Potts III, M.D.

Robert S. Rhodes, M.D.

William J. Scanlon, Ph.D.

Bruce D. Schirmer, M.D.

Anthony J. Senagore, M.D.

Kenneth W. Sharp, M.D.

Richard C. Thirlby, M.D.

Thomas F. Tracy Jr., M.D.

Douglas S. Tyler, M.D.

R. James Valentine, M.D.

Nicholas B. Vedder, M.D.

Selwyn M. Vickers, M.D.

J. Patrick Walker, M.D.

Cameron D. Wright, M.D.

Boston, Mass.

Abington, Pa.

Norfolk, Va.

Philadelphia, Pa.

Chattanooga, Tenn.

LaCrosse, Wis.

Little Rock, Ark.

Columbus, Ohio

Washington, D.C.

Lexington, Ky.

Charlottesville, Va.

Boston, Mass.

Ann Arbor, Mich.

Portland, Ore.

Hartford, Conn.

Portland, Ore.

Seattle, Wash.

Little Rock, Ark.

Philadelphia, Pa.

Chicago, Ill.

Omaha, Neb.

Winston-Salem, N.C.

New York, N.Y.

Tucson, Ariz.

Salt Lake City, Utah

Houston, Texas

Philadelphia, Pa.

Oak Hill, Va.*

Charlottesville, Va.

Los Angeles, Calif.

Nashville, Tenn.

Seattle, Wash.

Providence, R.I.

Durham, N.C.

Dallas, Texas

Seattle, Wash.

Minneapolis, Minn.

Crockett, Texas

Boston, Mass.

* *Public member*

C. Committees, Component Boards and Advisory Councils

Standing Committees and Chairs

Credentials Committee

Thomas H. Cogbill, M.D.

General Surgery Residency Committee

Stanley W. Ashley, M.D.

Advanced Surgical Education Committee

John B. Hanks, M.D.

Diplomates Committee

Richard C. Thirlby, M.D.

Component Boards and Advisory Councils

Vascular Surgery Board

Joseph L. Mills, M.D., <i>Chair</i>	Frank R. Lewis Jr., M.D. (<i>ex officio</i>)
Michael C. Dalsing, M.D.	Samuel R. Money, M.D.
John F. Eidt, M.D.	Amy B. Reed, M.D.
Vivian Gahtan, M.D.	Robert S. Rhodes, M.D. (<i>ex officio</i>)
Karl A. Illig, M.D.	R. James Valentine, M.D.
K. Craig Kent, M.D.	

Pediatric Surgery Board

Thomas F. Tracy Jr., M.D., <i>Chair</i>	Frank R. Lewis Jr., M.D. (<i>ex officio</i>)
Mary E. Fallat, M.D.	David J. Schmeling, M.D.
Henri R. Ford, M.D.	Charles J. H. Stolar, M.D.
Ronald B. Hirschl, M.D.	

Trauma, Burns and Critical Care Board

J. Wayne Meredith, M.D., <i>Chair</i>	Frank R. Lewis Jr., M.D. (<i>ex officio</i>)
L. D. Britt, M.D.	Pamela A. Lipsett, M.D.
William G. Cioffi Jr., M.D.	Robert C. Mackersie, M.D.
Richard L. Gamelli, M.D.	David W. Mercer, M.D.
Lenworth M. Jacobs Jr., M.B.B.S.	Lena M. Napolitano, M.D.
Gregory J. Jurkovich, M.D.	Michael F. Rotondo, M.D.

Gastrointestinal Surgery Advisory Council

Kenneth W. Sharp, M.D., <i>Chair</i>	David M. Mahvi, M.D.
Reid B. Adams, M.D.	Adrian E. Park, M.D.
Eric J. DeMaria, M.D.	Bruce D. Schirmer, M.D.
Stephen R. T. Evans, M.D.	Anthony J. Senagore, M.D.
Dennis L. Fowler, M.D.	Nathaniel J. Soper, M.D.
John G. Hunter, M.D.	Richard C. Thirlby, M.D.
Frank R. Lewis Jr., M.D. (<i>ex officio</i>)	

Surgical Oncology Advisory Council

Fabrizio Michelassi, M.D., <i>Chair</i>	Jeffrey F. Moley, M.D.
B. Mark Evers, M.D.	Mitchell C. Posner, M.D.
Jeffrey E. Gershenwald, M.D.	Richard A. Prinz, M.D.
Nathalie M. Johnson, M.D.	Rache M. Simmons, M.D.
V. Suzanne Klimberg, M.D.	Douglas S. Tyler, M.D.
Frank R. Lewis Jr., M.D. (<i>ex officio</i>)	Selwyn M. Vickers, M.D.

Transplantation Advisory Council

Douglas W. Hanto, M.D., <i>Chair</i>	Frank R. Lewis Jr., MD. (<i>ex officio</i>)
Joseph B. Cofer, M.D.	Charles M. Miller, M.D.
Andrew S. Klein, M.D.	Kim M. Olthoff, M.D.

D. Senior Members, Former Officers and Executive Staff

Senior Members

Frank F. Allbritten Jr., M.D.	1958-1964
K. Alvin Merendino, M.D.	1958-1964
William H. Muller Jr., M.D.	1959-1965
C. Rollins Hanlon, M.D.	1961-1967
Wiley F. Barker, M.D.	1964-1970
Ben Eiseman, M.D.	1964-1970
John M. Beal, M.D.	1965-1971
William R. Waddell, M.D.	1967-1973
Marshall J. Orloff, M.D.	1969-1972
W. Gerald Austen, M.D.	1969-1974
Isidore Cohn Jr., M.D.	1969-1975
George D. Zuidema, M.D.	1969-1976
William Silen, M.D.	1970-1973

John A. Mannick, M.D.	1971-1977
Vallee L. Willman, M.D.	1971-1977
Frank G. Moody, M.D.	1972-1978
Harry A. Oberhelman, Jr., M.D.	1972-1978
John H. Davis, M.D.	1973-1979
Judson G. Randolph, M.D.	1973-1979
Seymour I. Schwartz, M.D.	1973-1979
Walter Lawrence Jr., M.D.	1974-1978
Marc I. Rowe, M.D.	1974-1978
F. William Blaisdell, M.D.	1974-1980
Larry C. Carey, M.D.	1974-1982
William J. Fry, M.D.	1974-1982
Hiram C. Polk Jr., M.D.	1974-1982
Arlie R. Mansberger Jr., M.D.	1974-1983
Stanley J. Dudrick, M.D.	1974-1984
Arthur E. Baue, M.D.	1975-1981
Robert E. Hermann, M.D.	1975-1981
John E. Connolly, M.D.	1976-1982
Lazar J. Greenfield, M.D.	1976-1982
Donald G. Mulder, M.D.	1976-1984
E. Thomas Boles Jr., M.D.	1977-1981
Walter F. Ballinger, M.D.	1977-1982
Ward O. Griffen Jr., M.D.	1977-1983
Thomas M. Holder, M.D.	1977-1983
Morton M. Woolley, M.D.	1977-1985
G. Robert Mason, M.D.	1977-1986
Richard E. Ahlquist Jr., M.D.	1978-1984
Robert W. Gillespie, M.D.	1978-1984
Stephen J. Hoye, M.D.	1978-1984
Thomas J. Krizek, M.D.	1979-1983
John W. Braasch, M.D.	1979-1985
Donald D. Trunkey, M.D.	1980-1987
Robert E. Condon, M.D.	1981-1987
Albert W. Dibbins, M.D.	1981-1987
Richard D. Floyd M.D.	1981-1987
LaSalle D. Leffall Jr., M.D.	1981-1987
James A. O'Neill Jr., M.D.	1981-1987
John L. Sawyers, M.D.	1981-1987
Malcolm C. Veidenheimer, M.D.	1981-1987
Arthur J. Donovan, M.D.	1981-1988
Samuel A. Wells Jr., M.D.	1981-1989
Lewis M. Flint, M.D.	1982-1988
Bernard M. Jaffe, M.D.	1982-1988
John S. Najarian, M.D.	1982-1988
Basil A. Pruitt Jr., M.D.	1982-1988
Jeremiah G. Turcotte, M.D.	1982-1988
John A. Waldhausen, M.D.	1982-1988
George E. Cruft, M.D.	1982-2004
Paul M. Weeks, M.D.	1983-1987
P. William Curreri, M.D.	1983-1989
Ronald K. Tompkins, M.D.	1983-1989
Alfred A. de Lorimier, M.D.	1983-1990
George F. Sheldon, M.D.	1983-1990
Harvey W. Bender Jr., M.D.	1984-1989
Murray F. Brennan, M.D.	1984-1990
R. Scott Jones, M.D.	1984-1990
James E. McKittrick, M.D.	1984-1990
H. Brownell Wheeler, M.D.	1984-1990
Edward M. Copeland III, M.D.	1984-1991
Richard O. Kraft, M.D.	1985-1988
Marc I. Rowe, M.D.	1985-1991
Andrew L. Warshaw, M.D.	1985-1993
James A. DeWeese, M.D.	1986-1991
Charles M. Balch, M.D.	1986-1992
Kirby I. Bland, M.D.	1986-1992
John L. Cameron, M.D.	1986-1992
Jerry M. Shuck, M.D.	1986-1994
Arnold G. Diethelm, M.D.	1987-1993
Ira J. Kodner, M.D.	1987-1993
Edward A. Luce, M.D.	1987-1993
Richard E. Dean, M.D.	1988-1994
Wallace P. Ritchie Jr., M.D.	1988-1994
Michael J. Zinner, M.D.	1988-1994
Layton F. Ridders, M.D.	1988-1995
William A. Gay Jr., M.D.	1989-1995

Keith A. Kelly, M.D.	1989-1995
Richard L. Simmons, M.D.	1989-1995
Jack R. Pickleman, M.D.	1989-1996
Jay L. Grosfeld, M.D.	1989-1997
Haile T. Debas, M.D.	1990-1996
Alden H. Harken, M.D.	1990-1996
David L. Nahrwold, M.D.	1990-1996
Robert B. Rutherford, M.D.	1990-1996
Calvin B. Ernst, M.D.	1991-1997
Josef E. Fischer, M.D.	1991-1998
Palmer Q. Bessey, M.D.	1992-1998
John M. Daly, M.D.	1992-1998
David M. Heimbach, M.D.	1992-1998
J. David Richardson, M.D.	1992-1999
Robert W. Beart Jr., M.D.	1993-1996
Henry W. Neale, M.D.	1993-1996
Richard H. Dean, M.D.	1993-1999
Glenn D. Steele Jr., M.D.	1993-2000
Laurence Y. Cheung, M.D.	1994-2000
Daniel L. Diamond, M.D.	1994-2000
Anthony A. Meyer, M.D.	1994-2000
Richard A. Prinz, M.D.	1994-2000
Ronald G. Tompkins, M.D.	1994-2000
Patricia J. Numann, M.D.	1994-2002
David Fromm, M.D.	1995-2001
David E. Hutchison, M.D.	1995-2001
Frank R. Lewis Jr., M.D.	1995-2001
Peter C. Pairolero, M.D.	1995-2001
William L. Russell, M.D.	1995-2001
Robert W. Barnes, M.D.	1996-2002
Robert D. Fry, M.D.	1996-2002
Donald J. Kaminski, M.D.	1996-2002
Mark A. Malangoni, M.D.	1996-2003
Ronald V. Maier, M.D.	1996-2004
G. Patrick Clagett, M.D.	1997-2003
Thomas M. Krummel, M.D.	1997-2003
Bradley M. Rodgers, M.D.	1997-2003
Timothy J. Eberlein, M.D.	1998-2004
Julie A. Freischlag, M.D.	1998-2004
Frank W. LoGerfo, M.D.	1998-2004
Bruce E. Stabile, M.D.	1998-2004
Barbara L. Bass, M.D.	1998-2005
Jeffrey L. Ponsky, M.D.	1998-2006
Richard L. Gamelli, M.D.	1999-2005
Marshall M. Urist, M.D.	1999-2005
William G. Cioffi, M.D.	2000-2006
Keith E. Georgeson, M.D.	2000-2006
James C. Hebert, M.D.	2000-2006
Keith D. Lillemo, M.D.	2000-2006
Michael S. Nussbaum, M.D.	2000-2006
Courtney M. Townsend Jr., M.D.	2000-2007
Timothy C. Flynn, M.D.	2000-2008
Luis O. Vasconez, M.D.	2001-2003
Irving L. Kron, M.D.	2001-2005
David V. Feliciano, M.D.	2001-2007
David N. Herndon, M.D.	2001-2007
Michael G. Sarr, M.D.	2001-2007
Theodore N. Pappas, M.D.	2001-2007
Jon S. Thompson, M.D.	2001-2007
Richard H. Bell Jr., M.D.	2002-2006
James W. Fleshman Jr., M.D.	2002-2008
Russell G. Postier, M.D.	2002-2009
Steven C. Stain, M.D.	2002-2010
Thomas Stevenson, M.D.	2003-2004
Jonathan B. Towne, M.D.	2003-2007
Carlos A. Pellegrini, M.D.	2003-2009
James A. Schulak, M.D.	2003-2009
Marshall Z. Schwartz, M.D.	2003-2009
Randolph Sherman, M.D.	2004-2006
Jeffrey B. Matthews, M.D.	2004-2010
John J. Ricotta, M.D.	2004-2010
William P. Schecter, M.D.	2004-2010
Ronald J. Weigel, M.D.	2004-2010
Larry R. Kaiser, M.D.	2005-2008

Former Officers

Chairs

Evarts A. Graham, M.D.*	1937-1941
Allen O. Whipple, M.D.*	1941-1943
Arthur W. Elting, M.D.*	1943-1945
Vernon C. David, M.D.*	1945-1947
Fordyce B. St. John, M.D.*	1947-1949
Warfield M. Firor, M.D.*	1949-1951
Warren H. Cole, M.D.*	1951-1953
Thomas H. Lanman, M.D.*	1953-1955
John D. Stewart, M.D.*	1955-1957
Gustaf E. Lindskog, M.D.*	1957-1958
Frank Glenn, M.D.*	1958-1959
J. Englebert Dunphy, M.D.*	1959-1961
William P. Longmire Jr., M.D.*	1961-1962
Robert M. Zollinger, M.D.*	1962-1963
K. Alvin Merendino, M.D.	1963-1964
Charles G. Child III, M.D.*	1964-1965
Eugene M. Bricker, M.D.*	1965-1966
C. Rollins Hanlon, M.D.	1966-1967
William D. Holden, M.D.*	1967-1968
John A. Schilling, M.D.*	1968-1969
Charles Eckert, M.D.*	1969-1970
John M. Beal, M.D.	1970-1971
David C. Sabiston Jr., M.D.*	1971-1972
G. Tom Shires, M.D.*	1972-1974
Lloyd M. Nyhus, M.D.*	1974-1976
Paul A. Ebert, M.D.*	1976-1978
John E. Jesseph, M.D.*	1978-1980
William J. Fry, M.D.	1980-1982
Robert Zeppa, M.D.*	1982-1984
Claude H. Organ Jr., M.D.*	1984-1986
Arthur J. Donovan, M.D.	1986-1988
Samuel A. Wells Jr., M.D.	1988-1989
George F. Sheldon, M.D.	1989-1990
Edward M. Copeland III, M.D.	1990-1991
C. James Carrico, M.D.*	1991-1992
Andrew L. Warshaw, M.D.	1992-1993
Jerry M. Shuck, M.D.	1993-1994
Layton F. Rikkers, M.D.	1994-1995
David L. Nahrwold, M.D.	1995-1996
Jay L. Grosfeld, M.D.	1996-1997
Josef E. Fischer, M.D.	1997-1998
J. David Richardson, M.D.	1998-1999
Glenn D. Steele Jr., M.D.	1999-2000
Frank R. Lewis Jr., M.D.	2000-2001
Patricia J. Numann, M.D.	2001-2002
Mark A. Malangoni, M.D.	2002-2003
Ronald V. Maier, M.D.	2003-2004
Barbara L. Bass, M.D.	2004-2005
Jeffrey L. Ponsky, M.D.	2005-2006
Courtney M. Townsend Jr., M.D.	2006-2007
Timothy C. Flynn, M.D.	2007-2008
Russell G. Postier, M.D.	2008-2009
Steven C. Stain, M.D.	2009-2010

Vice Chairs

Allen O. Whipple, M.D.*	1937-1941
Fred W. Rankin, M.D.*	1941-1945
Fordyce B. St. John, M.D.*	1945-1947
Samuel C. Harvey, M.D.*	1947-1949
Warren H. Cole, M.D.*	1949-1951
Calvin M. Smyth, M.D.*	1951-1953
John H. Mulholland, M.D.*	1953-1955
John H. Gibbon Jr., M.D.*	1955-1956
Frank Glenn, M.D.*	1956-1958
William A. Altemeier, M.D.*	1958-1959
Harris B. Shumacker Jr., M.D.*	1959-1961
H. William Scott Jr., M.D.*	1961-1962
K. Alvin Merendino, M.D.	1962-1963
William H. Muller Jr., M.D.	1963-1964
Eugene M. Bricker, M.D.*	1964-1965
Samuel P. Harbison, M.D.*	1965-1966
Marshall K. Bartlett, M.D.*	1966-1967

William H. Moretz, M.D.*	1967-1968
Charles Eckert, M.D.*	1968-1969
James D. Hardy, M.D.*	1969-1970
Richard L. Varco, M.D.*	1970-1971
David V. Habif, M.D.*	1971-1972
George L. Nardi, M.D.*	1972-1973
W. Dean Warren, M.D.*	1973-1975
George L. Jordan Jr., M.D.*	1975-1977
Seymour I. Schwartz, M.D.	1977-1979
G. Rainey Williams, M.D.*	1979-1981
Arlie R. Mansberger Jr., M.D.	1981-1983
Alexander J. Walt, M.D.*	1983-1985
Donald D. Trunkey, M.D.	1985-1987
Samuel A. Wells Jr., M.D.	1987-1988
George F. Sheldon, M.D.	1988-1989
Edward M. Copeland III, M.D.	1989-1990
C. James Carrico, M.D.*	1990-1991
Andrew L. Warshaw, M.D.	1991-1992
Jerry M. Shuck, M.D.	1992-1993
Layton F. Ridders, M.D.	1993-1994
David L. Nahrwold, M.D.	1994-1995
Jay L. Grosfeld, M.D.	1995-1996
Josef E. Fischer, M.D.	1996-1997
J. David Richardson, M.D.	1997-1998
Glenn D. Steele Jr., M.D.	1998-1999
Frank R. Lewis Jr., M.D.	1999-2000
Patricia J. Numann, M.D.	2000-2001
Mark A. Malangoni, M.D.	2001-2002
Ronald V. Maier, M.D.	2002-2003
Barbara L. Bass, M.D.	2003-2004
Jeffrey L. Ponsky, M.D.	2004-2005
Courtney M. Townsend Jr., M.D.	2005-2006
Timothy C. Flynn, M.D.	2006-2007
Russell G. Postier, M.D.	2007-2008
Steven C. Stain, M.D.	2008-2009
E. Christopher Ellison, M.D.	2009-2010

Secretary-Treasurers

J. Stewart Rodman, M.D.*	1937-1952
John B. Flick, M.D.*	1952-1963
Robert M. Moore, M.D.*	1963-1971
Francis A. Sutherland, M.D. (Associate)*	1965-1973
J.W. Humphreys Jr., M.D.*	1971-1984
Ward O. Griffen Jr., M.D.	1984-1994
Wallace P. Ritchie Jr., M.D.	1994-2002

* *Deceased*

Executive Staff

Executive Director

Frank R. Lewis Jr., M.D.

Associate Executive Director

Jo Buyske, M.D.

Associate Executive Director

Mark A. Malangoni, M.D.

Associate Executive Director for Vascular Surgery

Robert S. Rhodes, M.D.

General Counsel

Gabriel L. I. Bevilacqua, Esq.

Director of Psychometrics and Data Analysis

Thomas W. Biester

Operations Manager

Jessica A. Schreader

Information Technology Manager

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