The

AMERICAN BOARD *of* SURGERY

Booklet of Information

Surgery

2017 – 2018

Office of the Secretary
American Board of Surgery Inc.
Suite 860
1617 John F. Kennedy Boulevard
Philadelphia, PA 19103-1847
Tel. 215-568-4000
Fax 215-563-5718
www.absurgery.org

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 this information and bear ultimate responsibility for ensuring their training meets 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.

Applicants are encouraged to visit the ABS website at *www.absurgery.org* for the most recent updates.

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.

TABLE OF CONTENTS

(click above to go to page)

I. INTRODUCTION

A. Mission

The American Board of Surgery serves the public and the specialty of surgery by providing leadership in surgical education and practice, by promoting excellence through rigorous evaluation and examination, and by promoting the highest standards for professionalism, lifelong learning, and the continuous certification of surgeons in practice.

B. Purpose

The American Board of Surgery is a private, nonprofit, autonomous organization formed for the following purposes:

- To conduct examinations of acceptable candidates who seek certification or continuous 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.

C. History

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 ABS.

D. The Certification Process

The American Board of Surgery 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, professional 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 QE, the applicant is considered a candidate for certification and granted the opportunity to take the Certifying Examination (CE). If the candidate is also successful in passing the CE, 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 general surgery as defined in section I-E. 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.

E. Specialty of General Surgery Defined

1. Scope of General Surgery

General surgery is a discipline that requires knowledge of and responsibility for the preoperative, operative, and postoperative management of patients with a broad spectrum of diseases, including those which may require nonoperative, elective, or emergency surgical treatment. The breadth and depth of this knowledge may vary by disease category. Surgical management requires skill in complex decision making; general surgeons should be competent in diagnosis as well as treatment and management, including operative intervention.

2. The certified general surgeon demonstrates broad knowledge and experience in conditions affecting the:

- Alimentary Tract
- Abdomen Wall and its Contents
- Breast, Skin and Soft Tissue
- Endocrine System

In addition, the certified general surgeon demonstrates broad knowledge and experience in:

- Surgical Critical Care
- Surgical Oncology
- Trauma

3. The field of general surgery as a specialty comprises, but is not limited to, the performance of operations and procedures relevant to the areas listed above. It is expected that the certified surgeon will also have additional knowledge and experience relevant to the above areas in the following categories:

- Related disciplines, including anatomy, physiology, epidemiology, immunology, and pathology (including neoplasia).
- Clinical care domains, including wound healing; infection and antibiotic usage; fluid and electrolyte management; transfusion and disorders of coagulation; shock and resuscitation; metabolism and nutrition; minimally invasive and endoscopic intervention (including colonoscopy and upper endoscopy); appropriate use and interpretation of radiologic diagnostic and therapeutic imaging; and pain management.

4. The certified general surgeon also is expected to have knowledge and skills for diseases requiring team-based interdisciplinary care, including related leadership competencies. Certified general surgeons additionally must possess knowledge of the unique clinical needs of the following specific patient groups:

- Terminally ill patients, to include palliative care and pain management; nutritional deficiency; cachexia in patients with malignant and chronic conditions; and counseling and support for end-of-life decisions and care.
- Morbidly obese patients, to include metabolic derangements; surgical and non-surgical interventions for weight loss (bariatrics); and counseling of patient and families.
- Geriatric surgical patients, to include management of comorbid chronic diseases.
- Culturally diverse and vulnerable patient populations.

5. In some circumstances, the certified general surgeon provides care in the following disease areas. However, comprehensive knowledge and management of conditions in these areas generally requires additional training.

- Vascular Surgery
- Pediatric Surgery
- Thoracic Surgery
- Burns
- Solid Organ Transplantation

6. In unusual circumstances, the certified general surgeon may provide care for patients with problems in adjacent fields, such as obstetrics and gynecology, urology, and hand surgery.

F. Website Resources

The ABS website, *www.absurgery.org*, is updated regularly and offers many resources for individuals interested in ABS certification. Potential applicants are encouraged to familiarize themselves with the website. Applicants should use the website to submit an application, check the application's status, update personal information, register for an examination, and view recent exam 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 Admissibility*
- *Examination of Persons with Disabilities*
- *Flexible Rotations Policy*
- *Leave Policy*
- *Limitation on Number of Residency Programs*
- *Military Activation*
- *Osteopathic Trainees Policy*
- *Privacy Policy*
- *Public Reporting of Status*
- *Reconsideration and Appeals*
- *Re-entry to Residency Training After Hiatus*
- *Regaining Admissibility to General Surgery Examinations*
- *Representation of Certification Status*
- *Revocation of Certificate*
- *Substance Abuse*

II. REQUIREMENTS FOR CERTIFICATION

Admission to the ABS certification process is governed by the requirements and policies in effect at the time of application. All requirements are subject to change.

A. Essentials of General Surgery

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

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

Additional expected knowledge and experience in the above areas includes:

- Technical proficiency in the performance of core operations/procedures in the above areas, plus knowledge, familiarity, and in some cases technical proficiency, with the more uncommon and complex operations in each of the above areas.
- Clinical knowledge, including epidemiology, anatomy, physiology, clinical presentation, and pathology (including neoplasia) of surgical conditions.
- Knowledge of anaesthesia; biostatistics and evaluation of evidence; principles of minimally invasive surgery; and transfusion and disorders of coagulation.
- Knowledge of wound healing; infection; fluid management; shock and resuscitation; immunology; antibiotic usage; metabolism; management of postoperative pain; 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 postoperative care; management of comorbidities and complications; and knowledge of appropriate use and interpretation of radiologic and other diagnostic imaging.

B. Exam Admissibility: 7-Year Limit

Applicants for certification in surgery who completed residency in the 2012-2013 academic year or thereafter will have no more than seven academic years to achieve certification (i.e., pass both the QE and CE).

The seven-year period starts immediately upon completion of residency. If individuals delay in applying for certification, or fail to take an examination in a given year, they will lose exam opportunities. Individuals are encouraged to begin the certification process immediately after residency so they will have the full number of exam opportunities available to them.

If applicants are unable to become certified within seven years of completing residency, they are no longer eligible for certification and must pursue a readmissibility pathway to re-enter the certification process. See Section III for further information.

C. General Requirements

Applicants for certification in surgery must meet these general requirements:

- **Have demonstrated to the satisfaction of the program director** of a graduate medical education program in surgery accredited by the Accreditation Council for Graduate Medical Education (ACGME) or Royal College of Physicians and Surgeons of Canada (RCPSC) 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 when registering for the CE. A full and unrestricted medical license is not required to take the QE. **Temporary, limited, educational or institutional medical licenses will not be accepted for the Certifying Exam,** 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.

Rarely, the above requirements may be modified or waived by the ABS Credentials Committee if warranted by unique individual circumstances.

D. 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-J-2. Credit for Foreign Graduate Education.)*

E. 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 surgical disorders, and the technical knowledge and skills appropriate to be applied by a surgical specialist. This goal can best be attained by means of a progressively graded curriculum of study and clinical experience under the guidance and supervision of certified surgeons, which provides progression through increasing levels 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 general surgery, as outlined in section II-A, 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 total time required for the educational process should be sufficient to provide adequate clinical experience for development of sound surgical judgment and adequate technical skill. These requirements do not preclude additional needed educational experience beyond the minimum 60 months of residency, and program directors are encouraged to retain residents in a program as long as is required to achieve the necessary level of performance.

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, 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 clinical activity. All time away from clinical activity of two days or more must be accounted for on the application for certification. *(See also II-H. Leave Policy.)*

2. Specific Requirements

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

- **A minimum of five years of progressive residency education** following graduation from medical school in a program in general surgery accredited by the ACGME or RCPSC. *(See II-J-5 for policy regarding residents in osteopathic training programs.)*

  Repetition of a year of training at one clinical level may not replace another year in the sequence of training. For example, completing two years at the PGY-2 level does not permit promotion to PGY-4; **a categorical PGY-3 year must be completed** and verified by the ABS resident roster. The only exception would be in some cases when credit is granted for prior training outside the U.S. or Canada.

  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.

  Additionally, 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.

- **The 60 months of general surgery residency training at no more than three residency programs.** The three-program limit applies to the five years (PGY 1-5) of progressive clinical training in general surgery that are to be counted as the applicant's complete residency, regardless of whether these years were completed as a preliminary or categorical resident.

  If a resident completes a PGY year (e.g., PGY-1) at one institution and then repeats the same year at another institution, only one of these years will be counted as residency experience and only one of these programs will be included in the three-program limit. In addition, any credit granted for prior training outside the U.S. or Canada will be counted as one institution.

For applicants who trained at more than one program, documentation of satisfactory completion of all years in prior programs from the appropriate program directors must be submitted. Individuals who completed the five progressive years of residency at more than three programs will be required to repeat one or more years at a single institution to comply with the three-program limit.

- **No fewer than 48 weeks of full-time clinical activity in each residency year**, regardless of the amount of operative experience obtained. The remaining four weeks of the year are considered non-clinical time that may be used for any purpose. The 48 weeks **may be averaged** over the first three years of residency, for a total of 144 weeks required, and over the last two years, for a total of 96 weeks required.
- **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 outlined in section II-A.
- **No more than six months during all junior years (PGY 1-3) 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 12 months total during all junior years may be allocated to any one surgical specialty other than general surgery.
- **The programs *Advanced Cardiovascular Life Support* (ACLS), *Advanced Trauma Life Support* (ATLS®), *Fundamentals of Laparoscopic Surgery*™ (FLS).** Applicants are not required to be currently certified in these programs; however documentation of prior successful certification must be provided with the application.
- The ***ABS Flexible Endoscopy Curriculum***, for applicants who **complete residency in the 2017-2018** academic year or thereafter. The curriculum contains five levels that must be attained during residency. The final level includes successful completion of the *Fundamentals of Endoscopic Surgery*™ **(FES)** program. Applicants will need to provide documentation of FES certification with their application.
- **At least six operative and six clinical performance assessments** conducted by the program director or other faculty members while in residency. The ABS does not collect the assessment forms; when signing an individual's application, the program director will be asked to attest that the assessments have been completed. Sample forms and further details are available on the *Resident Assessment* page of our website.
- **The entire chief resident experience in either the content areas of general surgery, as outlined in section II-A, or thoracic surgery,** with no more than four months devoted to any one component. *(Exceptions will be made for residents who have been approved under the flexible rotations option; see II-J-3.)*

  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 minimum of 48 weeks over the PGY-5 and PGY-4 years.** 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.

  In certain cases, up to six months 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 Review Committee for Surgery (RC-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.

F. Operative Experience

- Applicants must have been the operating surgeon for a minimum of **850 operative procedures in the five years of residency**, including at least **200 operative procedures in the chief resident year**. The procedures must include operative experience in each of the content areas listed in section II-A.
- In addition, they must have **a minimum of 40 cases in the area of surgical critical care patient management**, with at least one case in each of the seven categories: ventilatory management; bleeding (non-trauma); hemodynamic instability; organ dysfunction/failure; dysrhythmias; invasive line management and monitoring; and parenteral/enteral nutrition.
- Applicants who completed residency in the 2014-2015 academic year or thereafter must also have participated as **teaching assistant in a minimum of 25 cases** by the end of residency.

Applicants are required to submit a report with their application 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 teaching assistant cases toward the 850 total; however these cases may not count toward the 200 chief year cases**. Applicants may not claim credit both as surgeon (surgeon chief or surgeon junior) and teaching assistant.

G. Upcoming Requirements

250 Cases by Beginning of PGY-3

Applicants who **began residency in July 2014** or thereafter will be required to have performed **at least 250 operations by the beginning of the PGY-3 year**. This requirement has been changed from the end of PGY-2 to provide more flexibility. The 250 cases can include procedures performed as surgeon or first assistant. Of the 250 cases, at least 200 must be either in the defined categories, endoscopies, or e-codes. A maximum of 50 non-defined category cases may be applied to this requirement. Cases will be tracked through the ACGME case log.

H. Leave Policy

Leave During a Standard Five-Year Residency

For documented medical conditions that directly affect the individual (**not** family leave), the ABS will accept **142** weeks of training in the **first three** years of residency and **94** weeks in the **last two** years of residency. **No approval is needed for this option.**

All other arrangements beyond the standard medical leave described above require **prior written approval** from the ABS. Such requests may only be made by the program director and must be sent in writing by mail or fax (no emails) to the ABS office. Requests should include a complete schedule of the resident's training with calendar dates, including all leave time. (*See Leave Policy on our website for more details.)*

6-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. 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.

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, volunteerism, educational opportunities, etc.

I. Ethics and Professionalism Policy

The ABS believes that certification in surgery carries an obligation for ethical behavior and professionalism in all conduct. The exhibition of unethical or dishonest behavior or a lack of professionalism by an applicant, examinee or diplomate may therefore cause the cancellation of examination scores; prevent the certification of an individual, or result in the suspension or revocation of certification at any subsequent time; and/or result in criminal charges or a civil lawsuit. 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. Individuals exhibiting such behaviors may have their exam scores canceled; be permanently barred from taking ABS examinations; be permanently barred from certification; reported to state medical boards; and/or legally prosecuted under state or federal law, including theft, fraud and copyright statutes.

Unethical behavior is specifically defined by the ABS 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; such efforts may also violate federal copyright law.

All applicants, examinees, or diplomates must fully cooperate in any ABS investigation into the validity, integrity or security of ABS examinations. All ABS examinations are copyrighted and protected by law; the ABS will prosecute violations to the full extent provided by law and seek monetary damages for any loss of examination materials. *(See also III-D-2. Examination Irregularities.)*

Possession of a currently valid, full and unrestricted state medical license is an absolute requirement for certification. If a state medical license after final decision is probated, restricted, suspended, or revoked, this will trigger a review by the ABS Credentials Committee at its next meeting. The committee will review the action, and determine if any action is required in regard to the diplomate's certificate in surgery. Normally the state action will be duplicated in regard to the certificate, but the committee after review may choose at its discretion to adopt either a more lenient or more stringent condition on the certificate if warranted by the nature of the disciplinary infraction. *(See also IV-C. Revocation of Certificate.)*

J. 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.

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 **at least six months** to ascertain that clinical performance is consistent with the level of credit requested. 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.

Residents must take the ABS In-Training Examination (ABSITE®) before any credit may be requested. The resident's scores on the ABSITE should be consonant with the level of credit requested.

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. Program directors who wish to advance residents to senior levels (PGY-4) must have obtained ABS approval prior to beginning the PGY-4 year; otherwise credit for these years will be denied.

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.

All requests for credit and related inquiries must come from the program director and be sent in writing by letter or fax (no emails). **Requests will not be approved unless all required documentation is submitted**. Requests for more than one year of credit, which require approval of the ABS Credentials Committee, must be submitted **by March 15**, to provide program directors with a decision by May 1. Program directors will be notified of credit decisions by letter from the ABS executive director.

(See Credit for Foreign Graduate Education on our website for full policy, including all required documentation.)

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.

International Rotations

The ABS will accept in certain circumstances rotations outside the U.S. or Canada toward its residency training requirements. If program directors wish to credit training abroad toward ABS requirements, they must fully justify

the reasons for it and receive approval for such training in advance. No such rotations will be permitted in the first (PGY-1) or last (PGY-5) year of residency training. Rotations must be at least four weeks in duration to be considered for credit.

To request approval for an international rotation, a letter should be sent by mail or fax (no emails) to both the ABS and the RC-Surgery, signed by both the program director and the designated institutional official (DIO). The program will receive separate approval letters; both must be received prior to implementation of the international rotation. See *International Training* on our website for further details regarding rotation criteria and information to be included in the request for credit.

3. Flexible Rotations Option

The ABS has instituted a policy to permit greater flexibility in the clinical rotations completed by general surgery residents. Program directors, with advance approval of the ABS, are allowed to customize up to 12 months of a resident's rotations in the last 36 months of residency to reflect his or her future specialty interest. No more than six months of flexible rotations are allowed in any one year. This is an entirely voluntary option for program directors and may be done on a selective case-by-case basis.

To request flexible rotations for a resident, a letter should be sent by mail or fax (no emails) to both the ABS and the RC-Surgery. The letter must be signed by both the program director and the DIO, and be accompanied by a block diagram outlining the specific resident's individualized rotations. Approval must be obtained for each individual resident, even if the program received approval in the past for the same arrangement. The program will receive separate approval letters from the ABS and RC-Surgery; both must be received prior to implementation of flexible rotations.

(*See Flexible Rotations on our website for the full policy, including a list of suggested rotations by specialty.*)

4. Re-entry to Residency Training After Hiatus

Residents who withdraw from one surgical residency and have a hiatus before entering another residency, during which they are not engaged in any structured academic surgical activity, may be expected to have some degradation of knowledge and skills during that time. Any hiatus and re-entry into training in which a resident has been absent from residency training for four or more years must be reviewed therefore by the ABS Credentials Committee and approved if the individual is to qualify for certification at completion of training. Failure to obtain such approval may result in refusal to admit the resident to the certification process despite completion of five years of accredited training.

Program directors who wish to accept such residents into their program should enroll them for a minimum five-month trial period to evaluate their clinical skills and training level, and subsequently send a report to the ABS providing the results of this trial period and the ABSITE score for the same year. Such approval would normally be requested by June 1 in a given year, and would be acted on at the June meeting of the Credentials Committee so the resident could enter the program on July 1 at the appropriate level.

(*See Re-entry After Hiatus on our website for full policy.*)

5. Osteopathic Trainees

The ABS established in 2015 a policy regarding the entry of osteopathic surgical residents into the ABS certification process, in light of the Single GME Accreditation System. These residents will be required to complete at a minimum the last three years of residency training (PGY 3-5) in an ACGME-accredited general surgery residency program.

(*See Osteopathic Trainees on our website for full policy .)*

6. Further 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 training. Upon applying for certification, residents who have transferred programs must provide this verification to the ABS.

In addition to its own requirements, the ABS adheres to ACGME program requirements for residency training in general surgery. These include that program directors must obtain RC-Surgery approval in these situations: (1) for resident assignments 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. Documentation of such approval or prior ABS approval should accompany the individual's application.

7. 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 ABS *Reconsideration and Appeals Policy*. 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

ABS examinations are developed by committees consisting of ABS directors and experienced diplomates nominated to serve as exam consultants. All are required to hold current, time-limited certificates and participate in the ABS Continuous Certification Program. Neither directors nor consultants receive any remuneration. All ABS examinations are protected under federal copyright law.

The ABS has aligned the content of its examinations with that of the *SCORE® Curriculum Outline for General Surgery*, available from *www.surgicalcore.org*.

A. The In-Training Examination (ABSITE)

The ABS offers annually to residency programs the In-Training Examination, a formative multiple-choice examination designed to measure the progress attained by residents in their knowledge of the applied science and the management of clinical problems related to surgery. The ABSITE is administered as a single examination to all residency levels in a secure online format.

The ABSITE is solely meant to be used by program directors as a formative 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 examinees. The examination is not available on an individual basis and is not required as part of the certification process.

Exam Irregularities: When irregular behavior on the ABSITE is detected, the residency program will be required to investigate the situation and submit a report of its findings, including its decisions regarding the individuals concerned. In addition, the ABSITE scores of individuals identified by the ABS as having been involved in the irregularities will not be released. The program will also be required to administer the ABSITE to all of its residents on the first day of the exam window for the next three years. See our *ABSITE page* for the full policy.

B. The Qualifying Examination (QE)

1. General Information

The Qualifying Examination is an eight-hour, computer-based examination offered once per year. The examination consists of approximately 300 multiple-choice questions designed to evaluate an applicant's knowledge of general surgical principles and applied science. Information regarding *exam dates and fees*, as well as an *exam content outline* (pdf), is available on our website.

Results are posted on the ABS website approximately four weeks after the exam. Examinees' results are also reported to the director of the program in which they completed their final year of residency.

Taking the QE After PGY-4: The ABS will permit residents who will successfully complete their PGY-4 year in June to apply for and take the QE. All requirements must be met — see section 4 on the following page for details.

2. QE 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 end of August** for the individual to be eligible for that year's QE. Regardless of the reason, programs must notify the ABS in writing in all cases where a resident will not complete the chief year by June 30.

Application *instructions* and the online application process are available from the ABS website. The individual who served as the applicant's program director during residency must attest 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 time away from training of two days or more for vacation, medical leave, etc., is reported accurately.
- Documentation of current or past certification in ACLS, ATLS, FLS and FES is provided.
- Cases are listed for patient care/nonoperative trauma, in addition to the 40 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.

Note that residents are not required to meet RC-Surgery defined category minimums at the time of application — they must only meet ABS requirements. 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.

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 and Exam Opportunities

An individual 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, ethics and professionalism. In addition, please note the following:

- Individuals will have **no more than seven academic years** following residency to complete the certification process (i.e., passing both the QE and CE).
- The seven-year period **begins upon completion of residency**, not when an individual's application is approved. If applicants delay in initiating the certification process after residency, they will lose opportunities to take and pass the QE.
- Once an application is approved, applicants will be granted a maximum of **four opportunities within a four-year period** to pass the QE, providing they applied for certification immediately after residency. 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 **four-year limit is absolute**.

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

4. Taking the QE After PGY-4

The ABS will permit residents who will successfully complete their PGY-4 year in June to apply for and take the QE. All training and application requirements must be met at the time of application, including, for the 2018 QE, at least 850 total cases, 200 chief year cases, 40 cases in surgical critical care, 25 teaching assistant cases, and current or past certification in ACLS, ATLS, FLS and FES.

Taking the exam after PGY-4 will count toward the four opportunities in four years that are granted to successfully complete the QE. However, the overall seven-year limit to achieve certification will not go into effect until completion of residency.

Upon completion of residency, these individuals will be required to submit information regarding their PGY-5 year, including rotations, non-clinical time and operative cases. The program director will also need to attest to this information and to the satisfactory completion of the entire residency experience. They will not have any official status with the ABS and will not be admissible to the CE until the ABS has verified the satisfactory completion of general surgery training. *(See Taking QE After PGY-4 on our website for more information.)*

5. QE Readmissibility

Individuals who are no longer admissible to the QE may regain admissibility through a variety of pathways by which an individual acquires and demonstrates additional surgical knowledge. For details on these pathways, please see *Regaining Admissibility to General Surgery Examinations* on our website.

Time Limitations

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

C. The Certifying Examination (CE)

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. It is the final step toward certification in surgery.

The CE is designed to assess a candidate's surgical judgment, clinical reasoning skills and problem-solving ability. Technical details of operations may also be evaluated, as well as issues related to a candidate's ethical and humanistic qualities.

The content of the CE is generally, though not exclusively, aligned with the *SCORE® Curriculum Outline for General Surgery*. The majority of the examination focuses on topics listed in the outline as ***Core***. The remainder covers topics listed as ***Advanced***, or complications of more basic scenarios. Candidates are expected to know how to perform and describe all *Core* procedures.

The CE is administered several times per year in various U.S. cities. The exams are conducted by ABS directors along with associate examiners who are experienced ABS diplomates. All examiners are active in the practice of surgery, hold current, time-limited certificates, and participate in the ABS Continuous Certification Program. The ABS makes every effort to avoid conflicts of interest between candidates and their examiners.

Please refer to the *CE section* of our website for further details about the CE, including exam dates, fees, the CE site selection process, and a candidate video. Exam results are posted on the ABS website within one week after the

final day of the exam. Examinees' results are also reported to the director of the program in which they completed their final year of residency.

2. Admissibility and Exam Opportunities

To be admissible to the CE, a candidate must have successfully completed the QE 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.** In addition:

- Individuals will be granted a maximum of **three opportunities within a three-year period** to pass the CE, immediately following successful completion of the QE.
- Candidates will be offered **one opportunity per academic year**. If a candidate chooses not to take the exam in a given year, this is considered a lost opportunity as the **three-year limit is absolute**.

All of the limits outlined above are absolute; exceptions will only be made for active duty military service outside the United States. Candidates are strongly encouraged not to delay taking the CE for the first time, as such delays may adversely affect performance.

Candidates who exceed the above limits will lose admissibility to the ABS certification process and must fulfill a readmissibility pathway if they still wish to pursue certification.

3. CE Readmissibility

Individuals who are no longer admissible to the CE may regain admissibility through a variety of pathways by which an individual acquires and demonstrates additional surgical knowledge. For details on these pathways, please see *Regaining Admissibility to General Surgery Examinations* on our website.

D. Special Circumstances

1. Exam Accommodations

Learning Disabilities

The ABS 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; see *Examination of Persons with Disabilities* on our website for further details. 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.

Medical-Related Accommodations

Individuals who will need accommodations at the testing center due to medical-related conditions (injury, breast feeding, diabetes, etc.) should include a formal written request when mailing their application items.

2. Exam Irregularities and Unethical Behavior

Examination irregularities, i.e., cheating in any form, or any other unethical behavior by an applicant, examinee 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. *(See also II-I. Ethics and Professionalism.)*

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 and are currently compliant with a monitoring program documenting continued abstinence.

IV. ISSUANCE OF CERTIFICATES AND CONTINUOUS CERTIFICATION

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.

Diplomates who certify or recertify after July 1, 2005, must participate in the ABS Continuous Certification Program to maintain their certification. The ABS reserves the right to change the requirements of Continuous Certification 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's status as either *Certified* or *Not Certified*. In certain cases, one of the following descriptions may also be reported: *In the Examination Process, Clinically Inactive, Suspended* or *Revoked*. The ABS will also report whether a diplomate enrolled in Continuous Certification is meeting the program's requirements. Please refer to the *Public Reporting of Status* on the ABS website for definitions of the above terms.

Individuals may describe themselves as certified by the ABS or as an ABS diplomate only when they hold a current ABS certificate. Those whose certificates have expired will be considered not certified. A surgeon's status may be verified through *Check a Certification* on our website.

The ABS supplies biographical and demographic data on diplomates to the ABMS for its *Directory of Board Certified Medical Specialists*, which is available at *www.certificationmatters.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 Continuous Certification Program.

B. Continuous Certification

Continuous Certification is a program of ongoing professional development created by the ABS in conjunction with the ABMS and its other 23 member boards. It is intended to document to the public and the health care community the commitment of diplomates to lifelong learning and quality patient care.

The requirements of the ABS Continuous Certification Program are:

- ***Professional Responsibility*** – A full and unrestricted medical license; hospital/surgical center privileges (if clinically active); professional references; and participation in a practice improvement activity.
- ***Education and Assessment*** – Category 1 CME and self-assessment activities relevant to the surgeon's practice; and successful completion of an exam/assessment in the specialty.

Surgeons certified by the ABS are required to participate in Continuous Certification to maintain all ABS certificates they hold. Please refer to *Continuous Certification* on our website for more details.

C. Revocation 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 engaged in the unauthorized disclosure, publication, reproduction or transmission of ABS examination content, or had knowledge of such activity and failed to report it to the ABS.
- 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 status will be changed to *Not Certified* and the holder will be 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*. 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 the 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 examination to reinstate their certification. Upon passing the examination, they will be awarded a new, time-limited certificate and enrolled in the ABS Continuous Certification Program.

D. Certification in Surgical Specialties

The ABS has been authorized by the ABMS to award certification to individuals who have pursued specialized training and met defined requirements in certain disciplines related to general surgery: vascular surgery; pediatric surgery; surgical critical care (SCC); complex general surgical oncology; surgery of the hand; and hospice and palliative medicine.

Individuals seeking ABS certification in these specialties must fulfill the following requirements:

- Be currently certified by the ABS in general surgery (*see below 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 exams.

Further information regarding certification in these specialties is available from our website, *www.absurgery.org*.

Primary Certification in Vascular Surgery

A primary certificate in vascular surgery took effect July 1, 2006. Individuals who complete an accredited independent (5+2) or early specialization (4+2) vascular surgery program following general surgery residency are no longer required to obtain certification in general surgery prior to pursuing vascular surgery certification. However, these individuals must have an approved application for the General Surgery Qualifying Exam before entering the vascular surgery certification process, meeting all training and application requirements.

Surgical Critical Care: Exam While in Residency

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

Joint Training in Thoracic Surgery

Individuals may pursue an early specialization (4+3) pathway leading to certification in both general surgery and thoracic surgery through 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. See *Joint Pathway* on our website for details.

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.

National 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
Surgical Critical Care Program Directors Society

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 is highly desirable.

2017-2018 Officers

Mary E. Klingensmith, M.D., *Chair*
Spence M. Taylor, M.D., *Vice Chair*
Jo Buyske, M.D., *Secretary-Treasurer*

2017-2018 Directors

Fizan Abdullah, M.D.	Chicago, Ill.
Marwan S. Abouljoud, M.D.	Detroit, Mich.
Reid B. Adams, M.D.	Charlottesville, Va.
Roxie M. Albrecht, M.D.	Oklahoma City, Okla.
Mark S. Allen, M.D.	Rochester, Minn.
Marjorie J. Arca, M.D.	Milwaukee, Wis.
Kenneth S. Azarow, M.D.	Portland, Ore.
Russell S. Berman, M.D.	New York, N.Y.
Karen J. Brasel, M.D.	Portland, Ore.
Jo Buyske, M.D.	Philadelphia, Pa.
William C. Chapman, M.D.	St. Louis, Mo.
Dai H. Chung, M.D.	Nashville, Tenn.
Martin A. Croce, M.D.	Memphis, Tenn.
Dev M. Desai, M.D.	Dallas, Texas
Robert D. Fanelli, M.D.	Sayre, Pa.
David R. Farley, M.D.	Rochester, Minn.
Vivian Gahtan, M.D.	Syracuse, N.Y.
Mary T. Hawn, M.D.	Stanford, Calif.
O. Joe Hines, M.D.	Los Angeles, Calif.
Tyler G. Hughes, M.D.	McPherson, Kan.
Kenji Inaba, M.D.	Los Angeles, Calif.
K. Craig Kent, M.D.	Columbus, Ohio
Mary E. Klingensmith, M.D.	St. Louis, Mo.
Mark A. Malangoni, M.D.	Philadelphia, Pa.
M. Ashraf Mansour, M.B.B.S.	Grand Rapids, Mich.
Christopher R. McHenry, M.D.	Cleveland, Ohio
John D. Mellinger, M.D.	Springfield, Ill.
M. Timothy Nelson, M.D.	Albuquerque, N.M.
David T. Netscher, M.B.B.S.	Houston, Texas
Bruce A. Perler, M.D.	Baltimore, Md.
Nancy D. Perrier, M.D.	Houston, Texas
Anne G. Rizzo, M.D.	Falls Church, Va.
George A. Sarosi, M.D.	Gainesville, Fla.
Margo C. Shoup, M.D.	Warrenville, Ill.
David A. Spain, M.D.	Stanford, Calif.
Lee L. Swanstrom, M.D.	Portland, Ore.
Spence M. Taylor, M.D.	Greenville, S.C.
Mark L. Welton, M.D.	Minneapolis, Minn.
James F. Whiting, M.D.	Portland, Maine

C. Committees, Component Boards and Advisory Councils

Standing Committees and Chairs

Credentials Committee
Roxie M. Albrecht, M.D.

General Surgery Residency Committee
John D. Mellinger, M.D.

Advanced Surgical Education Committee
Lee L. Swanstrom, M.D.
Diplomates Committee
Margo C. Shoup, M.D.

Component Boards and Advisory Councils

Vascular Surgery Board

Vivian Gahtan, M.D., Chair
Kellie R. Brown, M.D.
Jo Buyske, M.D. (*ex officio*)
Daniel G. Clair, M.D.
Ronald L. Dalman, M.D.
Bernadette Aulivola, M.D.
Thomas S. Huber, M.D.
K. Craig Kent, M.D.
M. Ashraf Mansour, M.D.
Erica L. Mitchell, M.D.
Mark E. Mitchell, M.D.
C. Keith Ozaki, M.D.
Bruce A. Perler, M.D. (*ex officio*)
Vincent L. Rowe, M.D.
Malachi G. Sheahan, M.D.
Gilbert R. Upchurch Jr., M.D.

Pediatric Surgery Board

Kenneth S. Azarow, M.D., Chair
Fizan Abdullah, M.D.
Marjorie J. Area, M.D.
Mary L. Brandt, M.D.
Jo Buyske, M.D. (*ex officio*)
Dai H. Chung, M.D.
Mary J. Edwards, M.D.
Frederick J. Rescorla, M.D.
John H.T. Waldhausen, M.D.

Trauma, Burns and Critical Care Board

Martin A. Croce, M.D., Chair
Roxie M. Albrecht, M.D.
Karen J. Brasel, M.D.
Eileen M. Bulger,M.D.
Jo Buyske, M.D. (*ex officio*)
Kenji Inaba, M.D.
Krista L. Kaups, M.D.
Joseph P. Minei, M.D.
David T. Netscher, M.D.
Tina L. Palmieri, M.D.
Anne G. Rizzo, M.D.
David A. Spain, M.D.
Ronald M. Stewart, M.D.
Samuel A. Tisherman, M.D.

Surgical Oncology Board

Christopher R. McHenry, M.D., Chair
Reid B. Adams, M.D.
Mark S. Allen, M.D.
Peter D. Beitsch, M.D.
Russell S. Berman, M.D.
Jo Buyske, M.D. (ex officio)
Michael A. Choti, M.D.
Gerard M. Doherty, M.D.
Kelly K. Hunt, M.D.
Nancy D. Perrier, M.D.
Margo C. Shoup, M.D.
Kenneth K. Tanabe, M.D.

Gastrointestinal Surgery Advisory Council

Tyler G. Hughes, M.D., Chair
Jo Buyske, M.D. (*ex officio*)
Mark C. Callery, M.D.
Robert D. Fanelli, M.D.
O. Joe Hines, M.D.
Kenric M. Murayama, M.D.
Ninh T. Nguyen, M.D.
Aurora D. Pryor, M.D.
Daniel J. Scott, M.D.
Lee L. Swanstrom, M.D.
Mark L. Welton, M.D.

Transplantation Advisory Council

William C. Chapman, M.D., Chair
Marwan S. Abouljoud, M.D.
Jo Buyske, M.D. (*ex officio*)
Dev M. Desai, M.D.
Elizabeth A. Pomfret, M.D.
Dr. Peter G. Stock, M.D.
Dr. Lewis W. Teperman, M.D.
James F. Whiting, M.D.

General Surgery Advisory Council

Robert D. Fanelli, M.D., Chair
Jo Buyske, M.D. (*ex officio*)
David R. Farley, M.D.
Mary T. Hawn, M.D.
Tyler G. Hughes, M.D.
Mark A. Malangoni, M.D. (*ex officio*)
John D. Mellinger, M.D.
M. Timothy Nelson, M.D.
George A. Sarosi, M.D.

D. Senior Members, Former Officers, Executive Staff

Senior Members

Marshall J. Orloff, M.D.	1969-1972
W. Gerald Austen, M.D.	1969-1974
George D. Zuidema, M.D.	1969-1976
William Silen, M.D.	1970-1973
John A. Mannick, M.D.	1971-1977
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
Robert E. Hermann, M.D.	1975-1981
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
John W. Braasch, M.D.	1979-1985
Donald D. Trunkey, M.D.	1980-1987
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
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
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
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
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
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. Rikkers, 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
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
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. Lillemoe, 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
E. Christopher Ellison, M.D.	2003-2011
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
Stanley W. Ashley, M.D.	2004-2012
Larry R. Kaiser, M.D.	2005-2008
Karen R. Borman, M.D.	2005-2011
Leigh A. Neumayer, M.D.	2005-2011
John B. Hanks, M.D.	2005-2011
Jo Buyske, M.D.	2006-2008
Nicholas B. Vedder, M.D.	2006-2011
Lenworth M. Jacobs Jr., M.B.B.S.	2006-2012
Nathalie M. Johnson, M.D	2006-2012
J. Wayne Meredith, M.D.	2006-2012
Fabrizio Michelassi, M.D.	2006-2012
Kenneth W. Sharp, M.D.	2006-2012
Richard C. Thirlby, M.D.	2006-2012
Thomas F. Tracy Jr., M.D.	2006-2012
Thomas H. Cogbill, M.D.	2006-2013
J. Patrick Walker, M.D.	2006-2014
John R. Potts III, M.D.	2007-2012
L.D. Britt, M.D.	2007-2013
B. Mark Evers, M.D.	2007-2013
V. Suzanne Klimberg, M.D.	2007-2013
Joseph L. Mills, M.D.	2007-2013
Joseph B. Cofer, M.D.	2007-2014
David M. Mahvi, M.D.	2007-2015
Cameron D. Wright, M.D.	2008-2013
Bruce D. Schirmer, M.D.	2008-2014
Anthony J. Senagore, M.D.	2008-2014
R. James Valentine, M.D.	2008-2014
Douglas W. Hanto, M.D.	2009-2015
Ronald B. Hirschl, M.D.	2009-2015
Selwyn M. Vickers, M.D.	2009-2015
Stephen R.T. Evans, M.D.	2009-2016
John F. Eidt, M.D.	2010-2016
Gregory J. Jurkovich, M.D.	2010-2016
David W. Mercer, M.D.	2010-2016
Douglas S. Tyler, M.D.	2010-2016
John G. Hunter, M.D.	2010-2017
William J. Scanlon, M.D.	2010-2017
Kevin C. Chung, M.D.	2011-2014
Kevin E. Behrns, M.D.	2011-2017
Frederick A Luchette, M.D.	2011-2017
Lena M. Napolitano, M.D.	2011-2017

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
E. Christopher Ellison	2010-2011
Stanley W. Ashley, M.D.	2011-2012
Thomas H. Cogbill, M.D.	2012-2013
Joseph B. Cofer, M.D.	2013-2014
David M. Mahvi, M.D.	2014-2015
Stephen R.T. Evans, M.D.	2015-2016
John G. Hunter, M.D.	2016-2017
Mary E. Klingensmith, M.D.	2017-2018

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. Rikkers, 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
Stanley W. Ashley, M.D.	2010-2011
Thomas H. Cogbill, M.D.	2011-2012
Joseph B. Cofer, M.D.	2012-2013
David M. Mahvi, M.D.	2013-2014
Stephen R.T. Evans, M.D.	2014-2015
John G. Hunter, M.D.	2015-2016
Mary E. Klingensmith, M.D.	2016-2017
Spence M. Taylor, M.D.	2017-2018

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
Frank R. Lewis, M.D.	2002-2017

**Deceased*

Executive Staff

Executive Director – Jo Buyske, M.D.

Associate Executive Director – Mark A. Malangoni, M.D.

Associate Executive Director for Vascular Surgery – Bruce A. Perler, M.D.

General Counsel – Gabriel L.I. Bevilacqua, Esq.

Chief Operating Officer – Jessica A. Schreader

Director of Psychometrics and Data Analysis – Andrew Jones, Ph.D.

Director of Information Technology – James F. Fiore

Director of Communications and Public Affairs – Christine D. Shiffer