The
AMERICAN
BOARD
of
SURGERY

Booklet of Information
Surgery
2014–2015
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.
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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 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.

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 each content area of 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 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 generally 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. 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 (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/Burns and Emergency Surgery
- Vascular Surgery

General surgery as a field comprises, but is not limited to, the performance of operations and procedures (including endoscopies) relevant to the content areas listed above. 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 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).
- 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.

3. The following disciplines have training programs related to, but separate from and generally in addition to, 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.**

- Bariatric Surgery
- Solid 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
- Orthopaedic Injuries
- 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, surgery for weight loss, and the counseling of patients and families.
- Geriatric surgical patients, to include operative and nonoperative care, management of comorbid chronic diseases, and the counseling of patients and families.
- Culturally diverse groups of patients.
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 online application, check their application’s status, update their personal information, register for an examination, 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 Admissibility
- Examination of Persons with Disabilities
- Leave Policy
- Limitation on Number of Residency Programs
- Military Activation
- Privacy Policy
- Reconsideration and Appeals
- Re-entry to Residency Training After Hiatus
- Re-entry to Maintenance of Certification
- Re-entry to Surgical Practice
- Regaining Admissibility to General Surgery Examinations
- Reporting of Status
- 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. Exam Admissibility: Seven-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.

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 examination opportunities. 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.

B. 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 taking the Certifying Examination. A full and unrestricted medical license is not required to take the Qualifying Examination. **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.

C. 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-I-2. Credit for Foreign Graduate Education.)

D. 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 the specialty of surgery, as previously defined in section I-E, 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
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 surgical experience. All time away from clinical training of two days or more must be accounted for on the application for certification. (See also II-G. 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.

  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](http://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.

- **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 experience in each residency year.** This is required regardless of the amount of operative experience obtained. 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 previously defined in section I-E.

- **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®) and Fundamentals of Laparoscopic Surgery (FLS). Applicants are not required to be currently certified in these programs; however documentation of prior successful completion must be provided with the application.

• At least two operative and two clinical performance assessments conducted by the program director or other faculty members while in residency. This requirement will increase with applicants who complete residency in the 2015-2016 academic year: They will be required to have at least six operative and six clinical performance assessments.

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.

• The entire chief resident experience in either the content areas of general surgery, as defined in section I-E, 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-I-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 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.

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 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.
E. Operative Experience

• Applicants must have been the operating surgeon for a minimum of **750 operative procedures in the five years of residency**, 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-E.

• In addition, they must have a **minimum of 25 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 **complete 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 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.
F. Upcoming Requirements

250 Cases by End of PGY-2

Applicants who began residency in July 2014 or thereafter will be required to have performed at least 250 operations by the conclusion of the PGY-2 year. These can include cases performed as surgeon or first assistant, as well as endoscopies and operative exposures (e-codes). Of the 250 cases, at least 200 must be either in the defined categories, endoscopies, or e-codes. Cases will be tracked through the ACGME case log. The 250 cases must be completed in two consecutive residency years, ending with the PGY-2 year.

Flexible Endoscopy Curriculum

Applicants who complete residency in the 2017-2018 academic year or thereafter will be required to have completed the ABS Flexible Endoscopy Curriculum, available at www.absurgery.org. The curriculum contains several “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.

G. Leave Policy

1. Leave During a Standard Five-Year Residency

For documented medical problems or maternity 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. Unused vacation or leave time cannot be applied to reduce the amount of full-time experience 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. 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.

H. 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 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. The American Board of Surgery has adopted a “zero tolerance” policy toward these behaviors, and individuals exhibiting such behaviors may have their exam scores cancelled; 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 and such efforts may 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 Credentials 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.)

I. 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 (no emails or faxes). Requests for credit should only be submitted once all required documentation is available. Program directors will be notified of credit decisions by letter from the ABS executive director.

See www.absurgery.org for the complete 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.

To request approval for an international rotation, a letter should be mailed (no emails or faxes) to both the ABS and the RRC-Surgery, co-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. Further details regarding the information to be included in the request for credit are available from the ABS website, www.absurgery.org.
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 mailed (no emails or faxes) to both the ABS and the RRC-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 RRC-Surgery; both must be received prior to implementation of flexible rotations.

▶ See www.absurgery.org for the complete 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 www.absurgery.org for the complete re-entry policy.
5. 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 RRC-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.

6. 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, 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.
ABS examinations are developed by committees consisting of ABS directors and experienced diplomates nominated to serve as examination consultants. All are required to hold current, time-limited certificates and to participate in the ABS Maintenance of Certification (MOC) Program. Neither directors nor consultants receive any remuneration for their services. All ABS examinations are protected under federal copyright law.

The ABS has recently aligned the content of its examinations in surgery with that of the SCORE® Curriculum Outline for General Surgery Residency. The outline is available at www.absurgery.org or 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 basic sciences and the management of clinical problems related to surgery. As of 2014, the ABSITE is administered as a single examination to all residency levels. The exam is delivered in a secure 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 examinees. The examination is not available 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 instances there were cases of improper use, unacceptable test administration, or irregular behavior by individuals taking the examination.

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 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.

Exam results are mailed and posted on the ABS website two to three weeks after the exam. 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 QE. Application requirements and the online application process are available from the ABS website, www.absurgery.org.

Individuals who completed residency in the 2012-2013 academic year or thereafter will have no more than seven academic years following residency to complete the certification process. The ABS therefore encourages eligible individuals to apply for certification in their chief year of residency to ensure the maximum admissibility period. If individuals delay in applying for certification, they will lose examination opportunities.

The person 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 completion of ACLS, ATLS and FLS is provided.
- Cases are listed for patient care/nonoperative 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 and Examination Opportunities

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, ethics and professionalism.

With the transition to the new exam admissibility policy, the amount of time and number of exam opportunities granted for successful completion of the QE depends on when the applicant completed residency.

**Individuals who completed residency in the 2012-2013 academic year or thereafter:**

- These individuals will have **no more than seven academic years** following residency to complete the certification process. The seven-year period begins upon completion of residency, not when an individual’s application is approved.

- Once the application is approved, the applicant will be granted a maximum of **four opportunities within a four-year period** to pass the QE. 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**.

- The granting of four opportunities in four years is contingent on **sufficient time being left** in the applicant’s seven-year eligibility period.

**Individuals who completed residency prior to the 2012-2013 academic year:**

- These individuals must apply for certification within **three academic years** after completion of residency.

- Once their application is approved, they must take the Qualifying Examination **for the first time** in the year of application approval or the year following.

- The applicant will be granted a maximum of **five opportunities within a five-year period** to pass the QE. 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 exceed the above limits will lose admissibility to the ABS certification process and must fulfill one of the readmissibility pathways described in the next section if they still wish to pursue certification.
4. Readmissibility

Individuals who are no longer admissible to the ABS certification process may regain admissibility through the following pathways. For additional details on these pathways, please see Regaining Admissibility to General Surgery Examinations at www.absurgery.org.

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. The applicant must then complete an application for readmissibility and provide documentation of a current full and unrestricted medical license.

Upon application approval, the applicant will be admissible to the QE for four opportunities within four years. If the applicant does not pass the QE during this period, he or she must successfully complete two additional years of residency training at the PGY-4 and PGY-5 level in a surgery program accredited by the ACGME or RCPSC to regain admissibility for another four-year period.

Alternative Pathway

The individual may pursue an alternative educational pathway to acquire and demonstrate adequate surgical knowledge; all pathway requirements must be completed in the same year or 12-month period. The initial readmissibility application requires documentation of a current full and unrestricted medical license; evidence of 60 hours of Category I continuing medical education (CME) with self-assessment completed in the last 24 months; satisfactory completion of the American College of Surgeons’ Surgical Education and Self-Assessment Program (SESAP—this may be used to satisfy the aforementioned CME requirement); two reference letters; and a 12-month operative experience report.

Upon approval of the application, the applicant is granted one opportunity to take and pass a secure readmissibility examination derived from the ABSITE. Upon successful completion of this exam, the applicant is admissible to the QE for one opportunity, which must be taken in that same year.
Applicants who fail to successfully complete the ABSITE-based examination or the QE will be required to **repeat the entire pathway**, including the application process and examination, to regain admissibility to the QE. Up to **three** consecutive opportunities are permitted to successfully complete this pathway, including the QE. Once the three opportunities are exhausted, the applicant must pursue the standard pathway described in the previous section to regain admissibility to the certification process.

**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 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 to the certification process.

**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 examination focuses on the application of knowledge to clinical problems; evaluation of surgical judgment and decision making; management of complications; and assessment of technical knowledge.

   In the CE, approximately 75% of the content focuses on topics listed in the **SCORE Curriculum Outline** as Broad or Essential-Common (Core). The remainder covers topics listed as Focused, Essential-Uncommon or Complex (Advanced), or complications of more basic scenarios. As of 2013-2014 academic year, candidates are expected to know how to perform and describe all Essential-Common (Core) procedures.

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

   Please refer to [www.absurgery.org](http://www.absurgery.org) for further details about the CE, including exam dates, fees, the CE site
2. Admissibility and Examination 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.

The admissibility period to the CE begins upon successful completion of the QE. All CE candidates will be offered one opportunity per academic year in each year of admissibility to take the CE. If a candidate decides to not take the CE in a given year, it is a lost opportunity. As with the QE, the amount of time and number of exam opportunities granted for successful completion of the CE depends on when the applicant completed residency.

Individuals who completed residency in the 2012-2013 academic year or thereafter:

• These 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. If a candidate chooses not to take the examination in a given year, this is considered a lost opportunity as the three-year limit is absolute.

• The granting of three opportunities in three years is contingent on sufficient time being left in the applicant’s seven-year eligibility period.

Individuals who completed residency prior to the 2012-2013 academic year:

• These individuals will be granted a maximum of five opportunities within a five-year period to pass the CE. If a candidate chooses not to take the examination in a given year, this is considered a lost opportunity as the five-year limit is absolute.

Candidates who exceed the above limits will lose admissibility to the ABS certification process and must fulfill one of the readmissibility pathways described in the next section if they still wish to pursue certification.
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.

3. Readmissibility

Individuals who are no longer admissible to the CE may regain their admissibility through the following pathways. For additional details on these pathways, please see Regaining Admissibility to General Surgery Examinations at www.absurgery.org.

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. The applicant must then complete an application for readmissibility and provide documentation of a current full and unrestricted medical license.

Alternative Pathway

To regain admissibility to the CE through the alternative pathway, individuals must successfully complete the entire QE alternative pathway as described in section III-B-4.

Upon successful completion of either of the above pathways, the individual will be admissible to the CE for three opportunities within three years. If the individual is not successful in passing the CE during this period, he or she must successfully complete two additional years of residency training at the PGY-4 and PGY-5 level in a surgery program accredited by the ACGME or RCPSC to regain admissibility for another three-year period.

D. Special Circumstances

1. Persons with 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, 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.

2. Examination 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-H. 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.
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 for a period of 10 years, from the date of issuance through December 31 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 to maintain their certification. 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'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 the ABS MOC Program is meeting the program's requirements. Please refer to the Public Reporting of Status Policy 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. An individual's status may be verified at www.absurgery.org.

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 MOC Program.
B. Maintenance of Certification

Maintenance of Certification is a program of continuous professional development created by the ABS in conjunction with the ABMS and its other 23 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:

**Part 1: Professional Standing** – A full and unrestricted medical license, hospital/surgical center privileges and professional references

**Part 2: Lifelong Learning and Self-Assessment** – 90 hours of Category I CME credit relevant to your practice over a three-year cycle, with at least 60 of the 90 hours including self-assessment credit

**Part 3: Cognitive Expertise** – Successful completion of a secure MOC examination at 10-year intervals

**Part 4: Evaluation of Performance in Practice** – Ongoing participation in an outcomes registry or quality improvement program

Surgeons certified by the ABS are required to participate in the ABS MOC Program to maintain all ABS certificates they hold. MOC requirements run in three-year cycles. At the end of each cycle, diplomates must report to the ABS by completing an online form about their MOC activities. Please refer to www.absurgery.org for more information on current MOC requirements.

Surgeons who pass the secure exam (Part 3) prior to the expiration date of their certificate will receive a new certificate with an expiration date extending 10 years from the expiration date of the previous certificate.

The ABS considers MOC to be voluntary in the same manner as original certification. To ensure receipt of materials pertaining to MOC, diplomates should notify the ABS promptly of any changes of address.

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, 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 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 MOC 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.

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 the specialty of surgery: vascular surgery; pediatric surgery; surgical critical care (SCC); complex general surgical oncology; surgery of the hand; and hospice and palliative medicine.

Individuals seeking certification by the ABS in these specialties 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.
Further information regarding certification in these specialties is available from www.absurgery.org.

**Primary Certification in Vascular Surgery**

A primary certificate in vascular surgery took effect July 1, 2006. Individuals who complete an independent vascular surgery fellowship accredited by the ACGME or RCPSC following general surgery residency are no longer required to obtain certification in general surgery prior to pursuing vascular surgery certification.

However, applicants who complete an independent vascular surgery program must apply for the General Surgery Qualifying Exam before entering the vascular surgery certification process, meeting all training and application requirements. Upon approval of their General Surgery Qualifying Exam application, these individuals may then pursue certification in vascular surgery, or certification in both general surgery and vascular surgery, in whichever order they prefer.

**Surgical Critical Care: Examination 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 in an accredited surgery program available to them upon completion.

**Joint Training in Thoracic Surgery**

Individuals may pursue a 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 www.absurgery.org for further 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. 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
- 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 as a director, examination consultant or associate examiner is highly desirable.
2014-2015 Officers
David M. Mahvi, M.D., Chair
Stephen R.T. Evans, M.D., Vice Chair
Frank R. Lewis Jr., M.D., Secretary-Treasurer

2014-2015 Directors
Fizan Abdullah, M.D. Baltimore, Md.
Reid B. Adams, M.D. Charlottesville, Va.
Roxie M. Albrecht, M.D. Oklahoma City, Okla.
Mark S. Allen, M.D. Rochester, Minn.
Kenneth S. Azarow, M.D. Portland, Ore.
Kevin E. Behrens, M.D. Gainesville, Fla.
Karen J. Brasel, M.D. Portland, Ore.
William C. Chapman, M.D. St. Louis, Mo.
Dai H. Chung, M.D. Nashville, Tenn.
Martin A. Croce, M.D. Memphis, Tenn.
John F. Eidt, M.D. Greenville, S.C.
Stephen R.T. Evans, M.D. Columbia, Md.
Robert D. Fanelli, M.D. Sayre, Pa.
Vivian Gahtan, M.D. Syracuse, N.Y.
Douglas W. Hanto, M.D. Nashville, Tenn.
Tyler G. Hughes, M.D. McPherson, Kan.
John G. Hunter, M.D. Portland, Ore.
Gregory J. Jurkovich, M.D. Denver, Colo.
K. Craig Kent, M.D. Madison, Wis.
Mary E. Klingensmith, M.D. St. Louis, Mo.
Frederick A. Luchette, M.D. Maywood, Ill.
David M. Mahvi, M.D. Chicago, Ill.
Christopher R. McHenry, M.D. Cleveland, Ohio
John D. Mellinger, M.D. Springfield, Ill.
David W. Mercer, M.D. Omaha, Neb.
Lena M. Napolitano, M.D. Ann Arbor, Mich.
David T. Netscher, M.B.B.S. Houston, Texas
Anne G. Rizzo, M.D. Falls Church, Va.
William J. Scanlon, Ph.D.* Oak Hill, Va.
Margo C. Shoup, M.D. Warrenville, Ill.
Lee L. Swanstrom, M.D. Portland, Ore.
Spence M. Taylor, M.D. Greenville, S.C.
Douglas S. Tyler, M.D. Durham, N.C.
Selwyn M. Vickers, M.D. Minneapolis, Minn.
Mark L. Welton, M.D. Stanford, Calif.
James F. Whiting, M.D. Portland, Maine

*Public member

C. Committees, Component Boards and Advisory Councils

Standing Committees and Chairs
Credentials Committee
Douglas W. Hanto, M.D.

General Surgery Residency Committee
David W. Mercer, M.D.
Advanced Surgical Education Committee
Frederick A. Luchette, M.D.
Diplomates Committee
Margo C. Shoup, M.D.

Component Boards and Advisory Councils

Vascular Surgery Board
John F. Eidt, M.D., Chair
Daniel G. Clair, M.D.
Michael C. Dalsing, M.D.
Vivian Gahtan, M.D.
Karl A. Illig, M.D.
K. Craig Kent, M.D.

Pediatric Surgery Board
Ronald B. Hirschl, M.D., Chair
Fizan Abdullah, M.D.
Kenneth S. Azarow, M.D.
Mary L. Brandt, M.D.
Dai H. Chung, M.D.

Trauma, Burns and Critical Care Board
Gregory J. Jurkovich, M.D., Chair
Roxie M. Albrecht, M.D.
Karen J. Brasel, M.D.
Eileen M. Bulger, M.D.
Martin A. Croce, M.D.
David G. Greenhalgh, M.D.
Frank R. Lewis Jr., M.D. (ex officio)
Pamela A. Lipsett, M.D.

Surgical Oncology Board
Douglas S. Tyler, M.D., Chair
Reid B. Adams, M.D.
Mark S. Allen, M.D.
Peter D. Beitsch, M.D.
Russell S. Berman, M.D.
Michael A. Choti, M.D.
Gerard M. Doherty, M.D.

Gastrointestinal Surgery Advisory Council
John G. Hunter, M.D., Chair
Kevin E. Behrns, M.D.
Mark C. Callery, M.D.
Tyler G. Hughes, M.D.
Frank R. Lewis Jr., M.D. (ex officio)
David W. Mercer, M.D.

Transplantation Advisory Council
Douglas W. Hanto, M.D., Chair
William C. Chapman, M.D.
Andrew S. Klein, M.D.
Frank R. Lewis Jr., M.D. (ex officio)

General Surgery Advisory Council
Mary E. Klingensmith, M.D., Chair
Jo Buyske, M.D. (ex officio)
Robert D. Fanelli, M.D.
Tyler G. Hughes, M.D.
John G. Hunter, M.D.

D. Senior Members, Former Officers, Staff

Senior Members
Wiley F. Barker, M.D.
Ben Eiseman, M.D.
Marshall J. Orloff, M.D.
W. Gerald Austen, M.D.

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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
Frank G. Moody, M.D. 1972-1978
Harry A. Oberhelman Jr., M.D. 1972-1978
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. 1974-1978
Hiram C. Polk Jr., M.D. 1974-1982
Arlie R. Mansberger Jr., M.D. 1974-1983
Stanley J. Dudrick, M.D. 1974-1984
John E. Connolly, M.D. 1976-1982
Lazar J. Greenfield, M.D. 1976-1982
Donald G. Mulder, M.D. 1976-1984
Ward O. Griffen Jr., M.D. 1977-1983
Thomas M. Holder, M.D. 1977-1983
G. Robert Mason, M.D. 1977-1986
Robert W. Gillespie, M.D. 1978-1984
Stephen J. Hoey, 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
Albert W. Dibbins, M.D. 1981-1987
Richard D. Floyd M.D. 1981-1987
LaSalle D. Leffall Jr., M.D. 1981-1987
Malcolm C. Veidenheimer, M.D. 1981-1987
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
Jeremiah G. Turcotte, M.D. 1982-1988
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. 1984-1989
R. Scott Jones, M.D. 1984-1990
James E. McKittrick, M.D. 1984-1990
H. Brownell Wheeler, M.D. 1984-1990
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
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
Haile T. Debos, 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
John M. Daly, 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
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
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
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
Timothy C. Flynn, M.D. 2000-2008
Luis O. Vasquez, 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. 2003-2007
James A. Schulak, M.D. 2003-2007
E. Christopher Elliman, 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. 2004-2010
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
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
John A. Schilling, M.D.* 1968-1969
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. Eberth, M.D.* 1976-1977
John E. Jeseph, 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
Samuel A. Wells Jr., M.D. 1988-1989
George F. Sheldon, M.D.* 1989-1990
Andrew L. Warshaw, M.D. 1992-1993
Jerry M. Shuck, M.D. 1993-1994
Layton F. Rikkers, M.D. 1994-1995
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

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
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
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
Alexander J. Walt, M.D.* 1983-1985
Donald D. Trunkey, M.D.* 1985-1987
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
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

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.
Chief Operations Officer – Jessica A. Schreader
Director of Psychometrics and Data Analysis – Thomas W. Biester
Director of Information Technology – James F. Fiore
Director of Communications and Public Affairs – Christine D. Shiffer