



NEWSLETTER
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ABS NEWS

ABS Announces Changes to MOC Part 2

No more Category II CME, additional self-assessment

The American Board of Surgery will introduce changes in 2012 to Part 2 of the ABS Maintenance of Certification (MOC) Program. These changes are intended to simplify Part 2 requirements while providing some basic parameters as to the continuing medical education (CME) appropriate for lifelong learning and self-assessment. They are also aimed at giving diplomates the flexibility to create their own learning program. Diplomates are automatically enrolled in MOC upon certification or recertification in any ABS specialty after July 1, 2005.

CME

As of January 1, 2012, the ABS will no longer require Category II CME for either MOC or recertification. This reduces the overall amount of CME required. Category II CME activities are informal educational experiences, such as the reading of journals and teaching of residents. Diplomates will no longer have to report these activities on their three-year MOC form or recertification application.

The ABS will continue to require 90 hours of Category I CME over a three-year MOC cycle (unchanged). Category I CME activities are more formal educational experiences accredited by the AMA or ACCME, such as seminars, grand rounds, skills courses and departmental scientific meetings.

In terms of subject matter, the ABS requires only that CME be relevant to the diplomate's practice; there are no other restrictions. If the activity provides Category I CME credit and is relevant to your practice, it will count toward MOC Part 2. This includes CME completed to meet state licensing requirements and CME courses on topics such as ethics, patient safety, leadership, etc. If a diplomate is clinically inactive, the CME must be related to the broad discipline of surgery.

(Continued on page 3)

>> More about MOC inside

New Certificate in Complex General Surgical Oncology

First exam could be given as early as 2012



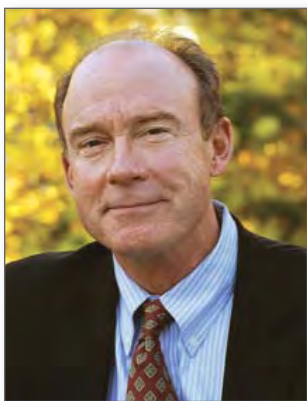
Dr. Fabrizio Michelassi, chair of the SOB-ABS, discusses the new certificate at a June 2011 meeting

of individuals to treat complex cases typically seen in cancer centers and specialized institutions, while at the same time recognizing that the vast majority of surgical oncology cases are, and will continue to be, treated by general surgeons practicing in the community.

The ABS received approval earlier this year to offer a new subspecialty certificate in complex general surgical oncology. The certificate will assess the qualifications

The certificate was put forward by the ABS after much deliberation regarding its effects on the practice of general surgeons. The ABS directors wanted to make certain the certificate would not negatively impact general surgeons who routinely treat cancer patients. The ABS' Surgical Oncology Board (SOB-ABS) worked with the Society for Surgical Oncology (SSO) to develop the certificate and specifically added the word "complex" to make clear it is intended for surgeons who treat complex cancer cases requiring intensive, multidisciplinary treatment. The ABS also examined the practice profile of surgeons who had completed SSO-approved surgical oncology fellowships and found their practice differed substantially from that of general surgeons.

(Continued on page 6)



STANLEY W. ASHLEY, M.D.
Chair of the ABS
2011-2012

Congress and has provided a strong voice for practicing general surgeons and residency program directors.

This has been a busy year for the ABS. The Maintenance of Certification program continues to evolve since its introduction in 2005. Based on a vision for continuous professional development, as opposed to a simple process of recertification every 10 years, the board has moved very deliberately with this initiative. This year, starting with a meeting in January led by past chair Dr. Christopher Ellison, we examined Part 2, lifelong learning and assessment. Although there was much concern regarding added work for our diplomates, all agreed that, unless we raise the bar for our CME process, we risk becoming increasingly irrelevant. In June, the board agreed to reduce the requirement from 50 hours per year of Category I and II CME to 30 hours of Category I alone, with 20 of the hours including self-assessment with a minimum score of 75%. There is general agreement that Part 4, evaluation of performance in practice, also needs to be strengthened and refined, and it is my hope that we might begin to address this over the coming year.

The ABS continues to focus considerable effort to address growing concerns regarding our training paradigm in coordination with the other member organizations of the Surgical Council on Resident Education (SCORE). The development of the SCORE curriculum for general surgery residency and the accompanying website with a host of learning tools is one major part of this effort. Dr. Mary Klingensmith, along with a

The ABS is pleased to welcome Dr. Joseph Cofer of Chattanooga, Tennessee as our new vice chair-elect. Dr. Cofer was elected to the ABS in 2007 as a representative of the Southeastern Surgical

newly appointed editorial board, is providing strong direction and the list of resources on the SCORE portal continues to grow. More than 90% of programs have subscribed to the website this year and plans are to expand the curriculum into other competencies.

Dr. Thomas Cogbill is leading an effort in conjunction with the Residency Review Committee for Surgery (RRC-Surgery) to develop an assessment tool that would satisfy the goals of the Accreditation Council for Graduate Medical Education's (ACGME) Milestone Project. This project seeks to develop a series of milestones in each competency that might be used not only to judge residents' progress during training, but also to objectify program evaluation by comparing the progress of a program's residents with national norms. The current ABS prerequisites of Advanced Cardiovascular Life Support, Advanced Trauma Life Support® and Fundamentals of Laparoscopic Surgery for entry into the certification process represent a form of "milestone" and, at our June 2011 meeting, we discussed additional requirements that would be appropriate. We continue to try to balance the need for such tools with the greater demands this will likely place on program directors, both in time and dollars.

During my seven years on the ABS I have been impressed with the board process; most decisions are vetted repetitively and over the course of several years before policy changes are initiated. However the board can move quickly when it needs to. Last February four gastroenterology societies distributed a policy statement suggesting that the standards and numbers being used for endoscopy by the ABS and the RRC-Surgery might not be adequate. The ABS, under the leadership of Dr. Jo Buyske, protested quickly and strongly, resulting in a joint statement by the societies and the ABS that numbers alone are not sufficient to define competence, and an agreement that the gastroenterologists, the ABS and related surgical societies would work together to arrive at a common standard.

As we proceed with these initiatives, we welcome your comments and feedback.



American Board of Surgery, Inc.

1617 John F. Kennedy Blvd, Suite 860
Philadelphia, PA 19103-1847
tel. (215) 568-4000
www.absurgery.org

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Changes to MOC Part 2 (cont.)

(Continued from page 1)

Self-Assessment

As of July 1, 2012, 60 of the 90 Category I CME hours required over three years must include a self-assessment activity—an increase from the current requirement of 30 hours. Self-assessment is a written or electronic question-and-answer exercise that evaluates a surgeon's understanding of the material presented during the CME program. The ABS believes self-assessment is important as it promotes active, rather than passive, learning, making it more likely that diplomates will apply what they have learned.

The board is purposely keeping self-assessment defined very broadly to be as inclusive as possible. Many live events, such as conferences and grand rounds, include a post-test or quiz that must be submitted for Category I CME credit. Category I CME provided by surgical journals (*JACS*, *Arch Surg*, etc.) and self-assessment exams (SESAP, VESAP) qualifies as self-assessment;

Diplomates who pass an ABS examination can now waive up to 60 hours of CME and self-assessment for MOC Part 2

Category I CME provided by textbooks and audio, video or web-based programs also typically contains self-assessment.

In addition, as of July 1, 2012, a score of 75% or higher must be attained on the self-assessment portion of the Category I CME activity for it to count as self-assessment. However there is no required minimum number of questions and repeated attempts are allowed. Individual CME programs may require a higher score at their discretion.

The ABS does not have an approval process for self-assessment activities. If the CME program meets the criteria stated above, it can be claimed as self-assessment. While the ABS website does list some available resources, diplomates should pursue whatever self-assessment is most relevant to their practice.

Your MOC Timeline										
Event that enrolled you in MOC: General Surgery Recertifying Examination (December 5, 2007)										
MOC Part	Year 1 July 1, 2008 - June 30, 2009	Year 2 July 1, 2009 - June 30, 2010	Year 3 July 1, 2010 - June 30, 2011	Year 4 July 1, 2011 - June 30, 2012	Year 5 July 1, 2012 - June 30, 2013	Year 6 July 1, 2013 - June 30, 2014	Year 7 July 1, 2014 - June 30, 2015	Year 8 July 1, 2015 - June 30, 2016	Year 9 July 1, 2016 - June 30, 2017	Year 10 July 1, 2017 - June 30, 2018
1 - Professional Standing										
Medical License										
Privileges										
References										
2 - Lifelong Learning and Self-Assessment more info										
CME Cat. I / Self-Assessment										
CME Cat. II										
3 - Cognitive Expertise										
Secure Examination (Surgery)										
4 - Evaluation of Performance in Practice more info										
Outcomes Database / QA Program										

Diplomates in MOC can view their own MOC timeline on the ABS website to track their participation

New! Exam Credit

The ABS has instituted a new policy to allow diplomates who pass an examination given by the ABS (or another ABMS board) for certification or recertification to waive up to 60 hours of CME and self-assessment for the three-year cycle in which they took the exam. This also applies to the examination that enrolled the diplomate in the ABS MOC Program—that exam may count toward the first MOC cycle. This policy applies to all diplomates enrolled in MOC since 2005. When completing the MOC form after a three-year cycle, diplomates should list the exam as an activity for Part 2.

The American Medical Association (AMA) will also issue Category I CME credits for certification or recertification by the ABS or another ABMS board. See www.ama-assn.org for more about direct CME credit.

Phase-In of New Requirements

For diplomates who as of July 1, 2012, will be in the middle of a three-year MOC cycle, the 60 hours of self-assessment required over three years will be prorated:

- Diplomates who will complete their current cycle as of July 1, 2013, will have to do an additional 10 hours, for 40 total hours of self-assessment.
- Diplomates who will complete their current cycle as of July 1, 2014, will have to do an additional 20 hours, for 50 total hours of self-assessment.

Diplomates can view a personalized MOC timeline on the ABS website to check their status.

Submitting Information

MOC cycles run from July 1 to June 30, beginning the July 1 following certification or recertification.

At the end of a three-year cycle, diplomates are required to submit an online form about their MOC activities, including CME completed for Part 2. No documentation is required at that time, though the ABS will audit a small number of forms each year. CME documentation is required as part of the recertification exam application.

Multiple Certificates

MOC is surgeon specific, not specialty specific. Diplomates who hold multiple certificates do not need to repeat MOC Part 2. They also do not need to repeat the three-year reporting. The CME should be related to their current scope of practice.

The ABS recognizes the dedication of diplomates to lifelong learning and welcomes your input as MOC Part 2 evolves.

Help us reach you!

The ABS will notify diplomates when action is required for MOC—please keep your contact information up to date by going to "Update Personal Information" under My Records/My Account on the ABS website

ABS MOC Requirements

Maintenance of Certification is divided into four parts. Diplomates begin MOC the July 1 following certification or recertification and are required to report on their MOC activities every three years by completing an online form. A secure exam is also required at 10-year intervals.

PART 1

Professional Standing

- Possession of a valid, full and unrestricted **medical license**
- Maintenance of hospital **privileges** in the specialty, if clinically active
If you do not hold privileges for whatever reason, you must explain why when completing the three-year reporting form
- Hospital **references**—name and contact information for the chief of surgery and chair of credentials at the institution where most work is performed

PART 2

Lifelong Learning and Self-Assessment

- A minimum of **90 hours of Category I CME** to be completed over a three-year cycle
- As of July 1, 2012, **60** of the Category I CME hours (30 previously) must include a **self-assessment activity**
Self-assessment is a question-and-answer exercise that assesses the surgeon's understanding of the material presented in the CME program
- As of July 1, 2012, a **score of 75% or higher** must be attained on the self-assessment portion of the CME activity for it to count as self-assessment. There is no required minimum number of questions and repeated attempts are allowed

PART 3

Cognitive Expertise

- Successful completion of a **secure examination** in the specialty, which may first be taken three years prior to certificate expiration
- A full application is required, including reference letters, 12-month operative log and CME documentation. Diplomates must be in compliance with MOC to apply
- For diplomates who hold multiple certificates from the ABS or another ABMS board, this is the **only requirement** that must be repeated for each specialty

PART 4

Evaluation of Performance in Practice

- Participation in a national, regional or local surgical **outcomes database or quality assessment program**. This includes programs such as NSQIP, PQRS, SCIP and the ACS case log system
Diplomates are encouraged to find out what programs are available to them through their hospital
- Periodic communication skills assessment based on patient feedback may also be required in the future

MOC > Frequently Asked Questions

Q. What is the three-year reporting requirement?

MOC requirements runs in three-year cycles (July 1-June 30), starting the July 1 following certification or recertification. Diplomates report on their MOC activities at the end of each cycle by completing an online form. Once you are enrolled in MOC, you can view a personalized MOC timeline on the ABS website to track your participation.

The online MOC form will be posted on your MOC timeline near the end of the three-year cycle. The form must be completed by Dec. 31 (six months after end of cycle). The online form asks for information about your medical license, hospital privileges, hospital references, CME/self-assessment activities from the past three years, and what practice assessment program(s) you are participating in.

No practice data is required, nor any paper documentation. Once you complete and submit the online form, no further action is required unless you are contacted by the ABS.

Q. What does the ABS consider self-assessment?

Self-assessment is a Category I CME activity that includes a written or electronic question-and-answer exercise that

assesses your understanding of the material presented during the CME program. Many live events, such as grand rounds and conferences, require a post-test before Category I CME credit is awarded. Category I CME provided by medical journals and self-assessment exams also would qualify. Category I CME derived from textbooks and audio, video or web-based programs also usually contains self-assessment.

Please note there is no ABS approval process for self-assessment activities. If the activity meets the guidelines above, it will count toward MOC Part 2. After July 1, 2012, diplomates must attain a score of 75% correct or higher for the CME activity to count as self-assessment.

Q. I hold two certificates—what do I need to do?

You should report to the ABS at three-year intervals according to the timeline of the certification/recertification that initiated your enrollment in the ABS MOC Program. The reporting does not have to be repeated for other ABS certificates. Diplomates in MOC who hold more than one certificate (ABS or another ABMS board) do not have to repeat Part 2 and Part 4 for each certificate. The Part 2 and Part 4 requirements should be completed

in whichever areas best reflect your practice. Only the secure examination (Part 3) must be completed for each certificate you hold.

MOC is surgeon specific, not specialty specific. **Once you are enrolled in MOC, you cannot take an ABS exam if you are not in compliance with MOC.** Diplomates who entered MOC by certifying or recertifying in general surgery but do not intend to maintain their general surgery certificate must still participate in MOC if they wish to certify or recertify in another specialty.

Q. What will happen if I don't participate in MOC?

Diplomates who do not report at three-year intervals or otherwise fail to meet MOC requirements will be reported as "Not Participating in MOC" and will face additional requirements should they wish to re-enter MOC at a later time. These requirements will increase the longer a diplomate is out of MOC. Diplomates who are not in compliance with MOC cannot certify or recertify in any ABS specialty until all MOC requirements are fulfilled.

For more MOC Q & A, visit the MOC section of www.absurgery.org

Why MOC Part 2? By Mark Malangoni, M.D., Associate Executive Director

MOC was designed to help physicians fulfill their professional obligation to maintain the necessary credentials for clinical practice and remain contemporary in the delivery of care. It consists of four components: professional standing; life-long learning and self-assessment; cognitive expertise; and practice improvement. These components are based on six competencies essential to the medical educational process, beginning in medical school, extending through residency training and culminating in practice. The American Board of Medical Specialties (ABMS), an umbrella organization of 24 medical specialty boards including the ABS, developed the broad requirements that all physicians must fulfill to maintain certification in their specialty. Participation in MOC satisfies the requirements of the various state medical boards for maintenance of licensure (MOL) and also satisfies OPPE as required by The Joint Commission. The remainder of this article will discuss Part 2 of MOC—lifelong learning and self-assessment.

First, a little background. When the American Medical Association was formed in 1847, it established two committees at its onset. These were the Committee on Ethics and the Committee on Medical Education. Fast forward to the formation of the American College of Surgeons (ACS) in 1912. The ACS was organized around the annual Clinical Congress, the purpose of which was to provide a forum for surgeons to learn from the scientific presentations of other qualified surgeons. The movement that resulted in the establishment of board certification for each medical discipline began shortly afterward. The boards were founded to uphold the quality of patient care by establishing standards for certification, including training requirements. Incorporated in the charters of the boards was the explicit requirement for physicians to remain current with changes in knowledge and skills in their practice.

It was expected that each physician would fulfill the professional obligation to seek out new knowledge and skills without question. Lo and behold when, in 1955, the AMA conducted a survey

among 5,000 of its members that demonstrated one-third of these physicians reported no participation in formal medical education over the previous five years. It's difficult to imagine not reading a professional journal or attending a local meeting in today's world. Nevertheless, this finding initiated efforts to require and later regulate continuing medical education activities. CME is now required by all 24 ABMS member boards and CME credits are required to be relicensed in 45 states.

There are some that believe that CME is a nuisance and unnecessary. Those naysayers should not forget the rapid pace of change in medical knowledge and practice, which presents a challenge for all of us in remaining contemporary in the management of our patients. These same patients expect that our recommendations for their care are based on the latest and most up-to-date information. Thus, CME provides an important role in ongoing education and documents our participation in lifelong learning.

“There are some that believe that CME is a nuisance and unnecessary. Those naysayers should not forget the rapid pace of change in medical knowledge”

The directors of the ABS recently reviewed our MOC program and made a number of changes effective in 2012. At that time the overall CME requirement will decrease from 50 to 30 hours per year through the elimination of Category II CME, as the board believes that surgeons already obtain this education in their everyday practice. The requirement for 30 hours of Category I CME credit yearly (i.e., 90 averaged over three years) fulfills all state licensure requirements. All CME must be “practice-related,” which allows diplomates to tailor their education based on their own practice environment. This definition allows any and all requirements of individual state medical boards to count for Part 2 of MOC as long as CME credit is provided for these activities. This permits our diplomates to meet the requirements of multiple regulatory agencies without an

additional burden. Diplomates who are no longer in the active clinical practice of surgery can fulfill the Part 2 MOC requirement by obtaining CME credits within the broad discipline of their specialty.

An additional change was to increase the requirement for self-assessment CME from 10 to 20 hours per year, averaged as 60 hours over a three-year MOC cycle. After a thorough discussion, the directors elected to make this change to demonstrate to the public our commitment to objectively measure the acquisition of knowledge and technical or patient management skills through CME-related activities. Surgeons have a long history of assessing their outcomes, and we believe obtaining this feedback results in improvements in surgical care. A passing score of 75% has been established as a benchmark for this measure, which is consistent with the educational standards for many of our other tests. Allowing limitless tries to meet this standard is also consistent with the principles of adult learning.

All of us have deterioration of our fund of knowledge over time. This is most evident in areas of knowledge that we use less frequently. Participation in meaningful CME activities has been demonstrated to improve patient outcomes and physician satisfaction over time (Keissling, 2010). A previous study done by the ABS established that greater CME activity also correlated with performance on the general surgery recertification examination (Rhodes, 2004).

Please take the time to familiarize yourself with the new requirements outlined on the previous pages. There are a number of venues to obtain Category I CME credit listed on the ABS website. We are actively working with professional organizations to increase in the near future the number of CME and self-assessment options available.



Cofer Named Vice Chair for 2012-2013



Joseph Cofer, M.D.
Vice Chair for 2012-2013

The ABS has elected Dr. Joseph B. Cofer as vice-chair for 2012-2013. He will serve as chair of the ABS in 2013-2014. Dr. Cofer was elected to the ABS in 2007 as a representative of the Southeastern Surgical Congress.

Dr. Cofer was born in Beckley, West Virginia and grew up in Chattanooga, Tennessee. He is professor of surgery and surgery residency

program director at the University of Tennessee College of Medicine (UTCOM) Chattanooga. Dr. Cofer completed his medical degree at UTCOM Memphis and then served in the U.S. Navy as a naval flight surgeon with Carrier Air Wing 15 in the Pacific Ocean. He completed his residency in general surgery at UTCOM Chattanooga. He also completed a fellowship in liver and kidney transplantation at

Baylor University Medical Center in Dallas. His clinical interests focus on general and hepatobiliary surgery. Earlier in his career, Dr. Cofer founded the liver transplant program at the Medical University of South Carolina in Charleston.

Through the Chattanooga-Hamilton County Medical Society, Dr. Cofer worked to create a community medical assistance program called "Project Access," which provides free medical care to low-income, uninsured residents. He remains involved in the program as a chair of its operations committee. Dr. Cofer is also extremely active in the surgical education community and has served as president of the Association of Program Directors in Surgery (APDS). He also serves as surgeon champion for the National Surgical Quality Improvement Program (NSQIP) at Baroness Erlanger Hospital in Chattanooga.

Dr. Cofer is currently chair of the ABS Qualifying Examination Committee and a member of the ABS Executive Committee, General Surgery Residency Committee and Transplantation Advisory Council.

New Certificate in Complex General Surgical Oncology (cont.)

(Continued from page 1)

The certificate will be offered to graduates of two-year training programs accredited by the ACGME, following completion of general surgery residency. These programs will seek to develop surgeons with specific knowledge of the diagnosis, multidisciplinary treatment and rehabilitation of patients with rare, unusual or complex cancers. The RRC-Surgery is currently developing the formal training requirements. The first training programs may be approved this academic year, with a possible first exam in the fall of 2012.

The issue of "grandfathering" was also debated extensively by the SOB-ABS and SSO. They decided against grandfathering as it would be extremely difficult to establish a fair basis for restricting eligibility to a certain number of years or a particular practice profile. Arbitrarily selecting individuals who completed surgical oncology fellowships in the last five years vs. last

ten years or some other length of time could not be defended. It would be equally difficult and arbitrary to grandfather general surgeons whose practice was focused in this area, since nearly all general surgeons perform some degree of oncologic surgery. Thus it was felt that the only valid and defensible manner in which to institute the new certificate was to offer it only to individuals who had completed an ACGME-accredited fellowship.

The SOB-ABS is currently developing the written and oral examinations to be required for certification. Candidates will be required to first obtain ABS certification in general surgery. Further information about the new certificate and its requirements will be posted on the ABS website as the certification process takes shape.

"This certificate opens a new chapter in the history of the American Board of Surgery," said Dr. Fabrizio Michelassi, SOB-ABS chair. "The cer-

tificate will recognize individuals who have received ACGME-approved training in the diagnosis and multidisciplinary treatment of patients with rare, complex and recurrent cancers, as well as training in community outreach and clinical research. As the current SSO-approved fellowships graduate only 50 surgical oncologists per year, the number of surgeons eligible for this certificate will be relatively small. Thus we foresee that this certificate will have minimal impact on the delivery of cancer care by general surgeons."

In Memory

It is with deep regret we report the death of the following past ABS director:

C. Rollins Hanlon, M.D.

05/03/11

ABS Updates

Survey Offers CME Credit at No Cost

In conjunction with the ABS, the University of Pennsylvania has developed a confidential online questionnaire that evaluates surgical decision making by asking surgeons to respond to 25 clinical scenarios. Feedback is provided comparing your responses with peers.

Survey participants receive five *AMA PRA Category 1 Credits™* at no charge. This CME also qualifies as self-assessment for MOC Part 2.

To take the survey, go to www.med.upenn.edu/cme/surgical_decision_making or visit the Part 2 resources page at www.absurgery.org. Questions may be directed to Dr. Niamey Wilson at niamey@mail.med.upenn.edu.

Update: “American Board of General Surgery”

Many diplomates alerted us last year when they were contacted by an “American Board of General Surgery” offering “membership” for a \$500 fee. The ABS filed suit last fall in federal court seeking an injunction against any further activity by this organization and the individual behind it, Dr. Keith A. Lasko. Dr. Lasko had also created and promoted several other entities, such as the “American Council of General Surgeons” and “American Board of Cosmetic and Plastic Surgery,” among others.

The ABS was successful in its suit and obtained a judgment from the U.S. District Court in Philadelphia that bars Dr. Lasko from engaging in fraudulent practices of this type in all 50 states. Thank you to all who brought this issue to our attention and sent copies of the letter they had received to support our case.

Recent ABS Journal Articles

The ABS was involved in several notable journal articles published recently. Currently in press but available online is “Effect of Program Type on the Training Experiences of 248 University, Community, and US Military-Based General Surgery Residencies” in the *Journal of the American College of Surgeons*.

The September 2011 issue of the *Annals of Surgery* features the articles “Feast or Famine?: The Variable Impact of Coexisting Fellowships on General Surgery Resident Operative Volumes” and “General Surgery Workloads and Practice Patterns in the United States, 2007 to 2009: A 10-Year Update from the American Board of Surgery.” The latter study showed that ABS diplomates perform an average of 533 procedures per year, an increase from 10 years ago.

The April 2011 *Journal of Vascular Surgery* contains “Comparison of Surgical Operative Experience of Trainees and Practicing Vascular Surgeons: a Report from the Vascular Surgery Board of the American Board of Surgery.”

A complete list of ABS journal articles is available at www.absurgery.org under “Publications.”

Congratulations to...

Dr. Lena Napolitano, ABS director, who has been elected chair of the ACS Board of Governors, and **Dr. William Cioffi**, member of the ABS’ Trauma, Burns and Critical Care Board, who was named secretary. In addition, **Dr. Lenworth Jacobs**, ABS director, has been elected to the ACS Board of Regents.



Lenworth Jacobs, MD, PhD

Another current ABS director, **Dr. Mary Klingensmith**, has been selected to receive the ACGME’s 2012 Parker J. Palmer Courage to Teach Award.

Accurately Representing Your Certification Status

A reminder that diplomates, as well as individuals currently in the process of certification or recertification, must accurately state their status at all times. This includes descriptions in curriculum vitae, advertisements, publications, letterhead and websites.

Individuals may describe themselves as certified by the ABS or as an ABS diplomate only when they hold a **current certificate**. Individuals who have allowed their certification to lapse may not use these descriptions without clearly indicating the certification is no longer valid. The ABS does not condone use of the term “board eligible” as it is indefinable. Please note as well that use of the ABS logo on websites, brochures, etc., by diplomates or institutions is not permitted.

Online Verification and News Feed

Don’t forget the ABS now provides **online verification** of certification at www.absurgery.org under “Is Your Surgeon Certified?” A PDF document is provided with the diplomate’s certificate number, certification history and current status. ABS website statistics show this feature is increasingly being used by patients to research their doctors. A mention of the search feature in the May issue of *Men’s Health Magazine*, for example, caused a significant uptick in its use on the ABS website.

The ABS also offers an **RSS news feed** with periodic brief updates from the board. A link to subscribe can be found in the top right of the ABS website. Most web browsers now offer free RSS reader programs.

Applying for an Exam Next Year?

The ABS posts its online application process each year in mid-April. We encourage you to visit www.absurgery.org now to view the application requirements for your exam. Diplomates who are eligible to apply for recertification in 2012 (certificate expiring in 2015 or earlier) will be notified when the online application process is available.

ABS Examines GI Endoscopic Training

Last February four gastroenterology societies—the American Association for the Study of Liver Diseases, American College of Gastroenterology, American Gastroenterological Association, and American Society for Gastrointestinal Endoscopy—published a position paper critical of ABS standards for endoscopic training. The paper stated that the numbers supposedly required by the ABS for resident training in endoscopy were insufficient to confer competence, while placing an undue burden on gastroenterologists.

In response, the ABS issued a statement to clarify its position, which was endorsed by 13 American and Canadian surgical organizations. The numbers for endoscopic procedures cited by the four societies were actually established

by the RRC-Surgery in 2006. The ABS does not maintain that any numerical standard alone defines competence in any procedure. Rather, the ABS believes hospital privileging must be predicated on a broader base of evaluation, including specialty certification, prior training and experience, and current outcomes in actual clinical performance.

Since then, the ABS has reached an agreement with the four societies that credentialing decisions involving endoscopy should be based on an evaluation of the physician's qualifications and skills, and not solely on a simple counting of procedures performed. The societies and the ABS also agreed to form a joint working group to develop recommendations on endoscopic training, to ensure that physicians perform-

ing endoscopy have appropriate training and education and to assist hospitals in assessing the competence of individuals requesting endoscopic privileges.

The societies are now working with the ABS and related surgical societies—the Society of American Gastrointestinal and Endoscopic Surgeons, American Society of Colon and Rectal Surgeons, Society for Surgery of the Alimentary Tract, and American Society for Metabolic and Bariatric Surgery—to develop an endoscopic training curriculum for general surgery residency. The ABS will also coordinate this effort with the APDS as the project progresses.

News from the Component Boards

Vascular Surgery (VSB-ABS)

When the vascular surgery primary certificate was established, individuals who completed general surgery residency before July 1, 2006, had to achieve general surgery certification prior to certification in vascular surgery. This policy has been eliminated—these individuals now need only pass the General Surgery Qualifying Examination or Surgical Principles Examination to be eligible for vascular surgery certification.

The VSB-ABS has also established a leave policy for integrated (0+5) program trainees similar to that for general surgery. In particular, it allows the five years of training to be completed over six years at the program's discretion. The new leave policy is posted on the ABS website under "Vascular Surgery."

The VSB-ABS has also approved the Society for Vascular Surgery's Vascular Quality Initiative for MOC Part 4.

Applicants to the 2014 Vascular Surgery Qualifying Examination and thereafter must possess the Registered Physician Vascular Interpretation (RPVI) credential. For more information on RPVI, see www.ardms.org/RPVI.

Pediatric Surgery (PSB-ABS)

The PSB-ABS successfully administered a modified exam format for the 2011 Pediatric Surgery Certifying Examination held last March. The exam now consists of five 30-minute sessions,

each dedicated to a different area of pediatric surgery: cancer; trauma and critical care; GI, hepatobiliary and abdomen; head/neck, endocrine and GU; and thoracic, airway and chest wall. In addition, all pediatric surgery examinations are now offered on an annual basis.

Applicants to the 2012 Pediatric Surgery Qualifying Examination and thereafter will be required to have completed the Pediatric Advanced Life Support (PALS) program offered through the American Heart Association (www.americanheart.org).

Surgical Oncology (SOB-ABS)

The SOB-ABS is working on a multiple-choice qualifying examination for the new certificate in complex general surgical oncology (see separate article). In addition, it has approved the National Quality Measures for Breast Centers® – Surgeon program for MOC Part 4.

Trauma, Burns and Critical Care (TBCCB-ABS)

The TBCCB-ABS is reviewing the SCORE curriculum, CoBaTrice competencies and the curriculum of the Surgical Critical Care (SCC) Program Directors Society to determine if gaps exist in SCC training. The goal is to ensure that general surgery residents and SCC fellows are receiving training in SCC appropriate in breadth and depth for their clinical level.

SCORE UPDATE

The Surgical Council on Resident Education continues to develop the General Surgery Resident Curriculum Portal, a website designed to provide high-quality educational materials aligned with the SCORE curriculum to residency programs. The website now features more than 400 modules on patient care, medical knowledge and systems-based practice, each with learning objectives, study questions, textbook chapters and videos. The modules also link directly to hundreds of radiologic and anatomic images. About 120 more modules are planned to be added this year.

In addition, the site includes access to the *ACS Surgery Weekly Curriculum and Evidence Based Reviews in Surgery*. It also features 1,500 multiple-choice questions for resident self-assessment. More than 220 residency programs and 8,000 residents are currently using the portal.

The latest edition of the *SCORE Curriculum Outline* was published in September, with a list of topics covering the patient care and medical knowledge competencies. It will eventually include the other four ACGME competencies. To view the outline or the latest news on SCORE, visit www.surgicalcore.org.

PROGRAM DIRECTORS' CORNER

12 Months of Flexibility

The ABS has instituted a new policy to permit general surgery program directors, with advance approval of the ABS, 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 is 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.

Requests for ABS approval should be made in advance by letter addressed to the ABS executive director and outline the plan for the flexible rotations. The ABS requirement that no more than four months in the chief year be devoted to any one area will be extended to six months, if necessary, upon approval. Please note this policy does not affect any of the ABS' other requirements for certification.

ABS Leave Policy Clarified

Applicants for general surgery certification must acquire no fewer than 48 weeks of full-time experience in each residency year. No more than four weeks of time off is allowed per year; the sole exception is approved medical leave (see next paragraph). All time away from training—for vacation, interviews, visa issues, early departures for fellowships, etc.—must be accounted for on the application for certification and cannot exceed a total of four weeks per year.

For documented medical problems or maternity leave, the ABS will accept 46 weeks of training in one of the first three years of residency and 46 weeks of training in one of the last two years, for a total of 142 weeks in the first three years and 94 weeks in the last two years. Unused vacation or leave time cannot be applied to reduce the amount of full-time experience required per year without prior written permission from the ABS.

If permitted by the residency program, the five clinical years of residency training may be completed over six academic years with advance approval from the ABS. All training must be completed at a single program. In this option, 48 weeks of full-time training are required in each clinical year. No block of clinical training may be shorter than one month (four weeks). Use of this option is solely at the program's discretion and contingent on ABS approval.

The complete leave policy is at www.absurgery.org under "General Surgery Qualifying Exam."

Credit for Foreign Graduate Medical Education

If a program director believes a resident to be a candidate for credit, the resident should be assigned to PGY-2 or PGY-3 so the appropriate level of clinical skills can be assessed. Program directors should make the request for credit only after having observed the individual as a junior resident for approximately six months. Residents must also take the ABS In-Training Examination (ABSITE) before credit is requested and their scores should be consonant with the level of credit requested.

Program directors who wish to advance residents to senior levels must obtain ABS approval prior to beginning the PGY-4 year. These candidates should complete at least six months of general surgery training at the PGY-3 level under the program director's supervision, or be participating in a surgical fellowship at the same institution.

Requests for three years of credit should include an operative log of cases completed by the candidate as operating surgeon during the PGY-3 or fellowship experience at the requesting institution. These candidates must also take the senior ABSITE at least once prior to the request for credit and demonstrate the expected level of knowledge for their level of training.

The full policy, including all required documentation, is available at www.absurgery.org. All requests for credit must come from the program director and be sent by letter to the ABS executive director.

International Rotations

The ABS will not normally accept any residency rotations outside the U.S. or Canada toward its requirements, even if completed as part of an accredited residency program. If program directors wish to credit training abroad toward ABS requirements, they must obtain approval in advance and the training must be completed under the direct supervision of a surgeon certified in general surgery by the ABS.

Upcoming Exam Dates

ABSITE: Jan. 27–31, 2012

PSITE: Feb. 18, 2012

VSITE: Feb. 25, 2012

Thank You to Our Examination Consultants and Examiners

The ABS gratefully recognizes the following individuals for their contributions to the ABS examination process

EXAMINATION CONSULTANTS

2011 GENERAL SURGERY QUALIFYING EXAMINATION

Peter Angelos, M.D.
Kevin E. Behrms, M.D.
Elisa H. Birnbaum, M.D.
Karen J. Brasel, M.D.
Kenneth W. Burchard, M.D.
Wendy J. Grant, M.D.
Richard A. Hodin, M.D.
A. Amy Mostafavi, M.D.
H. Leon Pachter, M.D.
Taine T. V. Pechet, M.D.
Nancy D. Perrier, M.D.
Patricia L. Turner, M.D.

2011 GENERAL SURGERY RECERTIFICATION EXAMINATION

R. Daniel Beauchamp, M.D.
William A. Billups III, M.D.
Joseph P. Minei, M.D.

2011 VASCULAR SURGERY EXAMINATIONS

Cameron M. Akbari, M.D.
Robert E. Engles, Jr., M.D.
Daniel M. Ihnat, M.D.
Mark D. Morasch, M.D.
John S. Munn, M.D.
Michael J. Rohrer, M.D.

2011 PEDIATRIC SURGERY EXAMINATIONS

Gary A. Birken, M.D.
Charles V. Coren, M.D.
R. Lawrence Moss, M.D.
Michael A. Skinner, M.D.
Charles L. Snyder, M.D.
Anthony Stallion, M.D.
Steven Stylianos, M.D.

2011 SURGICAL CRITICAL CARE EXAMINATIONS

Hasan B. Alam, M.D.
William C. Chiu, M.D.
Marianne E. Cinat, M.D.
Jonathan F. Critchlow, M.D.
Elizabeth B. Dreesen, M.D.
David J. Dries, M.D.
Gene A. Grindlinger, M.D.
Nicholas N. Nissen, M.D.
Patrick M. Reilly, M.D.
Lynette A. Scherer, M.D.
Samuel A. Tisherman, M.D.

2012 ABSITE (Clinical Mgmt. Section)

David J. Conti, M.D.
Lawrence L. Creswell, M.D.
George M. Fuhrman, M.D.
Rosemary A. Kozar, M.D.
John S. Lane, M.D.
Jeffrey M. Marks, M.D.
Fiemu E. Nwariaku, M.D.
A. Scott Pearson, M.D.
David W. Tuggle, M.D.

2012 ABSITE (Surgical Basic Science Section)

Colleen M. Brophy, M.D.
Saleem Islam, M.D.
Tien C. Ko, M.D.
Ronald F. Martin, M.D.

Aurora D. Pryor, M.D.
Melanie L. Richards, M.D.
Robert G. Sawyer, M.D.

2012 VASCULAR SURGERY IN-TRAINING EXAMINATION

Ahmed M. Abou-Zamzam Jr., M.D.
Ruth L. Bush, M.D.
Ronald L. Dalman, M.D.
David C. Han, M.D.
Erica L. Mitchell, M.D.
Timothy J. Nypaver, M.D.
John E. Rectenwald III, M.D.

2012 PEDIATRIC SURGERY IN-TRAINING EXAMINATION

Craig T. Albanese, M.D.
Kenneth S. Azarow, M.D.
Gail E. Besner, M.D.
Mike K. Chen, M.D.
Shirley Chou, M.D.
Patrick A. Dillon, M.D.
Kevin P. Lally, M.D.
Max R. Langham Jr., M.D.
Donald C. Liu, M.D.
Wallace W. Neblett III, M.D.
Jed G. Nuchtern, M.D.
Keith T. Oldham, M.D.
Pramod A. Puligandla, M.D.
Frederick J. Rescorla, M.D.
Marleta Reynolds, M.D.
Mark L. Silen, M.D.
Erik D. Skarsgard, M.D.
Samuel D. Smith, M.D.
John H. T. Waldhausen, M.D.
Mark L. Wulkan, M.D.

2010-2011 EXAMINERS

2011 PEDIATRIC SURGERY CERTIFYING EXAMINATION

Kenneth S. Azarow, M.D.
Edward M. Barksdale, M.D.
Mary L. Brandt, M.D.
Peter W. Dillon, M.D.
Peter F. Ehrlich, M.D.
Mary E. Fallat, M.D.*
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Barbara A. Gaines, M.D.
Ronald B. Hirschl, M.D.*
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Thomas F. Tracy Jr., M.D.*
David W. Tuggle, M.D.
Daniel von Allmen, M.D.
John H.T. Waldhausen, M.D.

2011 VASCULAR SURGERY CERTIFYING EXAMINATION

Cameron M. Akbari, M.D.
Hisham S. Bassiouny, M.D.
Michael Belkin, M.D.
John Blebea, M.D.
Thomas C. Bower, M.D.

Ruth L. Bush, M.D.
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Palma M. Shaw, M.D.
Cynthia E. Shortell, M.D.
W. Charles Sternbergh, M.D.
R. James Valentine, M.D.*
Fred A. Weaver, M.D.

GENERAL SURGERY CERTIFYING ASSOCIATE EXAMINERS

Fizan Abdullah, M.D.
Roxie M. Albrecht, M.D.
Edward J. Alfrey, M.D.
John C. Alverdy, M.D.
Spencer E. Amory, M.D.
Eric D. Anderson, M.D.
John R. Andrews, M.D.
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Benjamin Braslow, M.D.
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Tara M. Breslin, M.D.
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F. Charles Brunicardi, M.D.
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Harjeet Pal Singh Kohli, M.D.
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Lisa K. McIntyre, M.D.

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S. Robert Todd, M.D.
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Patricia L. Turner, M.D.
Jeffrey D. Wayne, M.D.
Sharon M. Weber, M.D.
Matthew V. Westmoreland, M.D.
John W. Winter IV, M.D.
David H. Wisner, M.D.
Jeffrey K. Zawacki, M.D.

* VSB/PSB-ABS member

Thank you to the following outgoing directors for their years of service to the ABS:

Karen R. Borman, M.D.
E. Christopher Ellison, M.D.
John B. Hanks, M.D.
Leigh A. Neumayer, M.D.

Meet Our New Directors

Kevin E. Behrns, M.D.

Birthplace: Wabasha, Minnesota
Hobbies: Bicycling, football, reading

College: University of St. Thomas (Minnesota)

Medical School: Mayo Medical School

Residency: Mayo Graduate School of Medicine

Research/Clinical Interests: Benign and malignant pancreatic diseases; lead NIH-funded laboratory of hepatobiliary and pancreatic pathobiology

Current Practice: Pancreatobiliary surgery

Academic Appointments: Chairman and Edward R. Woodward Professor of Surgery, University of Florida

Administrative Titles: Chief, Division of General Surgery, University of Florida – Gainesville, Fla.

Other Activities: Member, ACS Board of Governors; Member, Executive Council, ACS Florida Chapter; Editor, ACS Web Portal GI Surgery Community



Kevin C. Chung, M.D.

Birthplace: Taiwan

Hobbies: Writing, tennis, reading travel guides

College: Emory University

Medical School: Emory University

Residency: University of Texas at San Antonio

Clinical Fellowships: Plastic surgery, University of Michigan; hand surgery, Curtis National Hand Center

Research/Clinical Interests: Outcomes, health policy, clinical trials, economic modeling

Current Practice: Hand surgery and microsurgery

Academic Appointments: Professor of Surgery, University of Michigan

Administrative Titles: Assistant Dean for Faculty Affairs and Associate Director, Global REACH, University of Michigan Medical School – Ann Arbor, Mich.

Other Activities: Director, American Board of Plastic Surgery; Vice President for Research, American Society of Plastic Surgeons/Plastic Surgery Foundation



Mary E. Klingensmith, M.D.

Birthplace: Beckley, West Virginia

Hobbies: Cooking, water sports, keeping up with my children

College: Wellesley College

Medical School: Duke University

Residency: Brigham and Women's Hospital

Research/Clinical Interests: Graduate medical education—residency curricula, simulation, ethics training

Current Practice: General surgery

Academic Appointments: Mary Culver Distinguished Professor of Surgery, Washington University in Saint Louis

Administrative Titles: Vice Chair for Education and General Surgery Program Director, Washington University – St. Louis, Mo.

Other Activities: Associate Director, Washington University Simulation Center; SCORE Chair; Board Member, APDS and Association for Surgical Education; Faculty, ACS Surgeons as Educators Course



Frederick A. Luchette, M.D.

Birthplace: Sharon, Pennsylvania

Hobbies: Sports, reading

College: Thiel College

Medical School: University of Louisville

Residency: State University of New York at Buffalo

Research/Clinical Interests: Metabolic response to injury, thoracic trauma and respiratory failure

Current Practice: General surgery

Academic Appointments: Ambrose and Gladys Bowyer Professor of Surgery, Loyola University Chicago Stritch School of Medicine

Administrative Titles: Medical Director, General Surgery III Service; Chairman, Department of Surgery Promotion Committee, Loyola University Chicago Stritch School of Medicine – Maywood, Ill.

Other Activities: Secretary, Surgical Critical Care Program Directors Society; Vice President, Eastern Association for the Surgery of Trauma Foundation; Associate Editor, *The Journal of Trauma*



Lena M. Napolitano, M.D.

Birthplace: Waterbury, Connecticut

Hobbies: Travel, cooking

College: Boston University

Medical School: George Washington University

Residency: George Washington University Medical Center

Clinical Fellowships: Trauma and surgical critical care, University of North Carolina Hospitals

Research/Clinical Interests: Translational and outcomes research in trauma and surgical critical care with focus on multiple organ failure

Current Practice: Acute care surgery

Academic Appointments: Professor of Surgery, University of Michigan School of Medicine

Administrative Titles: Division Chief, Acute Care Surgery; Associate Chair, Dept. of Surgery; Director, Trauma and SCC, University of Michigan School of Medicine – Ann Arbor, Mich.

Other Activities: Chair, ACS Board of Governors; Member, ACS Committee on Trauma; Past Chair, Society for Critical Care Medicine–Surgical Section; Past President, Surgical Infection Society; Past Chancellor, Board of Regents, American College of Critical Care Medicine



Spence M. Taylor, M.D.

Birthplace: Greenville, South Carolina

Hobbies: Golf

College: Clemson University

Medical School: Medical University of South Carolina – Charleston

Residency: Medical University of South Carolina

Clinical Fellowships: Vascular surgery, Baylor College of Medicine

Research/Clinical Interests: Lower extremity peripheral arterial disease functional outcomes

Current Practice: Vascular surgery

Academic Appointments: Professor of Surgery, University of South Carolina School of Medicine

Administrative Titles: Chief Academic Officer and DIO, Greenville Hospital System; Senior Associate Dean of Academic Affairs and Diversity, USCSOM – Greenville, S.C.

Other Activities: President-elect, Southern Association for Vascular Surgery; Chairman, Institutional Self-Study Task Force for emerging medicine school on the Greenville Hospital System campus (USCSOM)





ABS NEWS

2011 Issue

The American Board of Surgery, Inc.
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103-1847
www.absurgery.org

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2010-2011 ABS Examination Statistics

Key: GS - General Surgery, ITE - In-Training Examination, VS - Vascular Surgery, PS - Pediatric Surgery, SCC - Surgery Critical Care, HS - Surgery of the Hand

Examination	Examinees	Pass Rate	Diplomates (to date)	Examination	Examinees	Pass Rate	Diplomates (to date)
GS Qualifying	1,378	80%	N/A	PS Qualifying	48	92%	N/A
GS Certifying	1,128	77%	57,622	PS Certifying	30	87%	1,156
GS Recertification	2,029	95%	20,014	PS Recertification	87	94%	768
ABSITE	7,773	N/A	N/A	PSITE	100	N/A	N/A
VS Qualifying	146	97%	N/A	SCC Certifying	161	93%	2,963
VS Certifying	129	84%	3,104	SCC Recertification	186	94%	1,407
VS Recertification	186	94%	1,946	HS Certifying	9	78%	260
VSITE	322	N/A	N/A	HS Recertification	14	93%	151

Your Surgeon Is Certified

The ABS offers the *Your Surgeon Is Certified* brochure to diplomates to educate patients about the significance of board certification. An order form and PDF preview are available at www.absurgery.org under "Publications." Copies can be ordered in quantities of 100, 200 or 500.



Your Surgeon is Certified by the American Board of Surgery

A surgeon certified in general surgery by the American Board of Surgery has training, knowledge, and experience related to the diagnosis and comprehensive management of surgical conditions in the areas listed below. This includes preoperative, operative, and post-operative care, as well as the treatment of complications in these areas.

General surgeons are also trained in minimally invasive (laparoscopic) surgery, ultrasonography and endoscopy (various techniques that employ endoscopic instruments to examine or treat internal organs, and which are commonly used in surgical management).

Areas in which general surgeons are trained to provide care:

- Digestive tract - esophagus, stomach, small intestine, large intestine, small and large colon
- Abdomen - stomach, diaphragm, biliary tract, liver, pancreas, spleen, and all types of hernias
- Breast - all types of benign and malignant disease
- Skin and underlying tissues - all types of benign and malignant disease
- Endocrine system - thyroid and parathyroid glands, pituitary and adrenal glands
- Heart and neck surgery - endocrine, benign and malignant disorders, thoracic ducts
- Pediatric surgery - surgical care of children, including newborns
- Surgical critical care - care of critically ill patients with surgical conditions requiring intensive care
- Surgical oncology - surgical management of cancer treatment and coordination of all aspects of cancer care
- Transplantology - including liver, kidney, pancreatic and small bowel
- Trauma and burns - all phases of care for the injured or burned patient from the emergency department to rehabilitation, including intensive care
- Vascular surgery - vascular surgery emergencies, vascular access surgery for dialysis patients, and other procedures involving arterial and venous

What is the American Board of Surgery?

The American Board of Surgery (ABS) was founded in 1937 through a joint effort of the American Surgical Association, American Medical Association, and the American College of Surgeons, as well as regional surgical societies. These organizations recognized the need for a board that would evaluate, certify and certify individuals who meet a standard of excellence in the field of surgery. Additionally, the ABS was charged with improving and broadening opportunities for the education and training of surgeons.

The American Board of Surgery is an independent, non-profit organization with worldwide recognition. It oversees six distinguished surgical specialties, research and practice, and represents the principal surgical organizations in the United States. The ABS is one of the 24 certifying boards that are members of the American Board of Medical Specialties.

