ABS to Pursue Primary Certificate in Vascular Surgery

A central focus of the January meeting of the American Board of Surgery (ABS) was the evolution of the field of vascular surgery, and the need for a certification program that reflects the changing practice of vascular surgeons. The issue of greater flexibility in vascular surgery training, and in particular the possibility of adopting a training pathway similar to plastic surgery—three years of general surgery followed by three years of vascular surgery (3+3)—has been discussed in the vascular surgery community in recent years, driven by the lessening role of abdominal surgery in vascular practice and the expanding role of endovascular therapies.

Currently, the vascular surgery certificate offered by the ABS is a subspecialty certificate and requires general surgery certification prior to vascular certification. Under the bylaws of the American Board of Medical Specialties (ABMS), a subspecialty certificate cannot be given independently, but must follow a primary certificate. The only method by which a 3+3 paradigm for vascular surgery could be realized is by the creation of a primary certificate in vascular surgery awarded by the ABS. Prior general surgical training would then not be required, and graduates of a 3+3 program would not obtain general surgical certification. Though the issuance of a second primary certificate is a landmark development for the ABS, the precedent for a board to award multiple certificates is well established by the ABMS, with five boards currently offering more than one primary certificate.

The ABS leadership, in accord with the leadership of the Society for Vascular Surgery (SVS), agreed to bring this proposal to the full ABS Board of Directors, and it was the first issue discussed at the January retreat. There was general support among participants for the proposal, with the common sentiment being that vascular surgery practice is evolving in a direction which requires less prior training in general surgery, and that this evolution should be recognized by a primary certificate in vascular surgery. The issue was reintroduced at the meeting of the full board, and a resolution was presented and unanimously approved to proceed with an application to the ABMS. The resolution stated, “The American Board of Surgery and Vascular Surgery Board (VSB) of the ABS will move forward to create a primary certificate in vascular surgery.”

The VSB, in collaboration with the SVS, will prepare an official proposal for a primary certificate in vascular surgery to be submitted to the ABMS in March 2004. The approval process will take a minimum of one year, and the proposal must be reviewed and approved by the other 23 boards of the ABMS. With the new certificate, while present training pathways would be continued, new pathways involving 3+3 programs—either integrated at one institution or independent at separate institutions—could potentially be developed for the future.
It is a pleasure to update you on the recent activities at the American Board of Surgery (ABS). It has been an exciting time and I believe the ABS has made significant progress in defining its course for the coming years. During the annual retreat in January, several years of active discussion and debate culminated in the following three resolutions.

The ABS, upon recommendation of the VSB and with support from the SVS and the Association of Program Directors in Vascular Surgery (APDVS), will apply to the ABMS for authority to create a primary certificate in vascular surgery, awarded by the ABS.

The principal consequences of this are elimination of the requirement for certification in general surgery prior to certification in vascular surgery. This creates the possibility of training paradigms that involve more than two years of vascular surgery training. A curriculum for primary vascular surgery certification will be developed by the VSB and APDVS, and will most likely consist of three years of core training in general surgery, followed by three years of training in vascular surgery, leading to a single certificate in vascular surgery. This will shorten the duration of training from the current five year paradigm and allow for development of expanded training in the rapidly evolving field of endovascular surgery. The VSB, SVS, and APDVS are currently collaborating on the application for the ABS. For individuals interested in certification in both general surgery and vascular surgery, the Early Specialization Program (ESP) currently being piloted offers dual certification and a reduced duration of training.

The second resolution dealt with redesigning surgical education and the development of a core training program in general surgery. This is the outcome of extensive discussions based on concerns about the variability of surgical training throughout the country, the variability in the end product of training, and the need to rethink and modify the core of general surgery training in response to the stresses and challenges created by the reduced 80-hour workweek. As a consequence, the ABS passed a resolution to develop, in conjunction with the Residency Review Committee for Surgery, the Association of Program Directors in Surgery, the Association of Surgical Education, and the American College of Surgeons, a uniform, standardized and benchmarked core training model.

The curriculum to be developed will define three or four years of training in the core principles of general surgery, which will be applicable to any field of subsequent specialization. Changes in the curriculum will evolve over the next few years and should provide greater uniformity in training across programs and greater assurance of covering the essential components of general surgery. There will be emphasis on education over service and achievement of skills and training benchmarks prior to advancement at different levels. Hopefully, in the future, outcomes assessment to ensure accomplishment of training goals rather than time-based requirements will evolve.

The third resolution was in response to ongoing concerns about increasing subspecialization and how to better organize the ABS to deal with the unregulated development of numerous subspecialty fellowships. The proliferation of unregulated fellowships has created concerns about the quality of training as well as the encroachments of these fellowships on the underlying general surgery residency. These concerns were well defined by a director, Dr. Keith Georgeson, at the annual meeting, “I feel that the ABS must make an effort to better organize and define the subspecialization that is spontaneously occurring in general surgery. Approximately 70% of current general surgery graduates continue some form of additional training in preparation for their surgical practice. The continued chaotic subspecialization process is unacceptable. It is a disservice to the American public, who do not have a clear knowledge of what a subspecialized general surgery certificate means, and is unfair to general surgeons who have found the value of their general surgery certificates progressively diminished by proliferating subspecialties in the field.”

The ABS will provide a framework for the evolution and maturation of these general surgical subspecialties as a part of general surgery, while at the same time protecting the integrity of general surgery as a specialty and providing a cohesive structure to hold the commonwealth of general surgical subspecialties together.

One can easily see the extensive evolution that is occurring at the ABS in response to the natural evolution of surgical training in America. It is hoped, with these resolutions, that the ABS can move forward to establish the processes and develop the infrastructure necessary to meet these challenging and exciting developments.

My best wishes for a successful and enjoyable year. The ABS looks forward to keeping you informed and asks for your feedback via the website or by mail at these discussions and programs mature.
Maintenance of Certification—What you need to know

What is Maintenance of Certification?

Maintenance of Certification (MOC) is a program of continuous professional development initiated in 2000 by the American Board of Medical Specialties (ABMS) and its 24 member boards. It is a process designed to document that physician specialists certified by the ABMS boards are maintaining the necessary skills and knowledge to provide quality patient care in their specialty. The program gives diplomates the opportunity to demonstrate to peers, patients, and the general public a commitment to lifelong learning and improvement in their chosen field of practice.

MOC is the new “gold standard” of specialty board certification. It acknowledges that diplomates have already demonstrated a commitment to excellence by becoming certified and builds upon this experience. MOC incorporates six core physician competencies, as defined by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME), into an evaluation process by which practicing surgeons can document their ongoing commitment to excellent patient care—the heart of the certification process.

Perhaps most importantly, MOC represents an opportunity for physicians to take a leadership position in the national movement to improve health care quality and patient safety, through performance assessments founded on objective clinical standards and measurable outcomes.

Why do we need this now?

MOC represents an evolution from existing recertification and was developed in response to growing public concerns regarding the quality of health care. Given the current health care environment, it has become critical that a commitment to quality health care delivery is documented on a continuing basis and not just at a ten-year recertification.

If physician organizations do not recognize the level of public dissatisfaction with perceived health care quality and take clear and effective steps to improve it, it is quite likely that external regulation by the federal government or other organizations, which would be far more onerous and less focused on important clinical issues, will be forthcoming. The ABMS is working to see that the federal government, third party payers and state licensing boards recognize MOC and use it to replace current and future requirements.

What does MOC specifically entail?

The ABMS, in conjunction with the ACGME, has defined six general competencies as the foundation for physicians’ training and practice characteristics during their professional lifetime. These six competencies are:

- Medical knowledge about established and evolving biomedical, clinical and cognate sciences, and the application of this knowledge to patient care;
- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health;
- Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and other health professionals;
- Professionalism as demonstrated by a commitment to professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population;
- Practice-based learning and improvement that involves investigation and evaluation of one’s own patient care, appraisal and assimilation of scientific evidence, and improvement in patient care; and
- Systems-based practice, as demonstrated by an awareness of and responsiveness to the entire system of health care, and the ability to effectively call on system resources to provide optimal care.

Using this framework, the MOC program will consist of four key components that will measure these competencies on a continual basis:

1. Evidence of professional standing;
2. Evidence of commitment to lifelong learning through continuing education and involvement in a periodic self-assessment process;
3. Evidence of cognitive expertise based on performance on an examination, such as a recertification examination;
4. Evidence of evaluation of performance in practice, including outcome measurements of the medical care provided, assessment by peer and referring physicians, and evaluation of physician behaviors such as communication and professionalism, by peer review or other means.

Each ABMS board has been charged with creating and implementing an individualized plan incorporating these components based on its specialty’s needs. The assessment mechanisms to be used will be integrated into the recertification requirements already in place.

As an ABS Diplomate, what does this mean to me?

The ABS is developing its specific MOC program with full consideration for the time demands of a practicing surgeon. The ABS MOC requirements are designed to fulfill the above key components in the most efficient and flexible way. Many of the requirements are already required for recertification, though the frequency may be different under MOC. Professional standing, commitment to life-long learning, and evaluation of practice performance will be evaluated at periodic intervals through the current 10-year recertification cycle. Evidence of cognitive expertise, demonstrated by satisfactory performance on a secure examination, will still occur at 10-year intervals.

The initiation of the MOC program for evidence of professional standing, commitment to lifelong learning, and cognitive expertise will begin with diplomates recertifying in 2005 and thereafter. Those who have recertified prior to this date will enter the MOC process only when they seek to renew their present certification.

(Continued on page 6)
Education and Training Committee to Develop National Curriculum

Last year, the ABS established a Curriculum Committee charged with evaluating and identifying needed curricular improvements in surgical training. As a result of its work, the committee has recommended several initiatives to make residency training more uniform and effective for all participants:

- A defined national curriculum for residency;
- Development of a modular framework for the teaching of surgery;
- Specific attention to the teaching of the six competencies as defined by the Accreditation Council for Graduate Medical Education;
- Better assessment of competency during residency progression, with advancement where possible based on demonstration of competency as opposed to strictly time-based advancement;
- More specific and validated skills training early in residency; and
- Greater use of non-clinical teaching modalities where available (simulation, virtual reality, computer-based teaching).

The Curriculum Committee and other ABS committees during the last year have discussed at length various alternatives to the present five-year residency model. The most common proposals have been for core training of three or four years, followed by a specialty or subspecialty pathway for an additional one to three years. However, no consensus has been reached about an acceptable change to the present system, as multiple logistic problems arise in virtually all of the systems that have been debated. As a result, the ABS Board of Directors at its January meeting made a decision to focus first on the development of more effective residency training, and to defer revising the basic residency paradigm until demonstrated improvements in training are achieved.

The following resolution was adopted unanimously at the Board meeting: “The American Board of Surgery, in conjunction with other major stakeholders, will develop a standardized core surgical training program based where possible on progressive milestones and documented competence.”

To accomplish this, the ABS Board of Directors voted to make the Curriculum Committee a standing committee renamed the Education and Training Committee, and to establish working relationships with the other stakeholders involved in surgical resident education—the American College of Surgeons, the Association of Program Directors in Surgery, the Residency Review Committee for Surgery, the Association for Surgical Education, the American Surgical Association, and other surgical boards. Dr. Richard Bell, committee chair, will lead the development of a strategic plan for the committee, commencing with the PGY-1 year and subsequent residency years. The ABS will keep its constituencies apprised of all developments as the committee’s work continues.

ABS Addresses Oversight of Post-Residency Fellowships

A major topic of discussion at the January board meeting was the ongoing quality of post-residency surgical fellowships, which are now elected by approximately 70% of general surgery residency graduates. The fellowships that are certificated (vascular surgery, pediatric surgery, surgical critical care, surgery of the hand) or overseen by other ABMS boards (thoracic, plastic, colon-rectal) are carefully regulated by the respective Residency Review Committees of the Accreditation Council for Graduate Medical Education. Some of the non-certificated specialties (transplant, surgical oncology) are accredited by the respective surgical societies and have detailed requirements. However, many non-certificated specialties are relatively unregulated and are not subject to any uniform oversight. While some fellowships are well managed, many are not subject to any specific requirements, are not site visited, and have variable standards. The ABS Board of Directors believes that greater uniformity in the standards and oversight of non-accredited fellowships is needed and has directed the ABS staff to work with the relevant specialty societies to better define general requirements and oversight.

One element of addressing this task will be the creation of additional advisory councils within the ABS structure, which will work directly with the respective specialty societies to develop uniform post-residency fellowship requirements. The ABS is currently defining these areas of practice and the steps to be taken over the next few months toward implementing this objective. The ABS will then bring additional recommendations back to the next full board meeting in June.

The following resolution was adopted unanimously by the board: “The American Board of Surgery will develop the infrastructure to support the oversight and evaluation of advanced surgical training.” In adopting this resolution, it was also noted that specialties evolve over time, and a flexible fellowship model that can address this evolution is essential for the protection of the public. As some of these specialties mature, the need for a certification process may arise, though no such programs are planned at this time.
**TECHNOLOGY UPDATE**

### Computer-Based Exams Meet With Candidates’ Approval

In 2003, the ABS transferred all specialty recertification examinations (vascular surgery, pediatric surgery, surgical critical care, surgery of the hand) from paper format to a user-friendly computer-based exam held in testing centers across the country. This pilot program was so successful that it will be expanded for 2004 to include the general surgery recertification examination, the qualifying examination in vascular surgery, and the certifying examination in surgical critical care.

As in the past, once the examination application is submitted and approved by the ABS, candidates will receive a reply card to be returned to the ABS to confirm that they will be taking the examination that fall. When the ABS receives the completed reply card and examination fee, candidates will be sent an admission letter with the date or dates in which that particular exam will be given at the Pearson VUE™ testing centers. Candidates will be instructed in the letter to visit Pearson VUE’s website, www.pearsonvue.com, to locate a testing center near them and to contact that center to reserve a date and time. Reservations will be on a first-come, first-served basis as the testing centers have limited capacity and are used by multiple organizations.

Recertification examinees will have a two-week window in which they can take the exam at a Pearson VUE testing center. In contrast, the qualifying examination for vascular surgery and the written certifying examination for surgical critical care will only be given on a single day, so candidates should schedule their examinations as soon as they receive their admission letters.

Pearson VUE, the testing vendor selected by the ABS, is a company with 200 testing centers and 2,000 available seats nationwide. All of the centers are uniform in size, testing equipment, appearance, and procedures, and are specifically restricted to professional testing, rather than all types of certification testing.

The new computer-based format will give ABS examinees more flexibility in scheduling their examinations and reduce travel time and expense. While the computer-based exams are currently identical to the traditional paper examinations in terms of question content and structure, the ABS expects in the future to employ exam formats that take full advantage of the computer technology.

This past October, approximately 350 diplomates took the specialty recertification examinations, and the testing went smoothly with a high degree of satisfaction noted in post-test questionnaires.

### ABS Applications to Go Online

Beginning in 2004, the ABS is introducing an online application process for the qualifying examinations and all recertification examinations via its website, www.absurgery.org. Rather than filling out a paper application, applicants will now log in to the website to quickly and easily prepare their applications and operative reports online. This change will facilitate the application process for exam candidates and enable more efficient processing of applications in the ABS office. The online application function will be available as of Monday, March 8, on the ABS website and complete instructions for the online process will be provided at that time.

It is important to note that the application process will continue to involve the submission of paper copy that cannot be sent electronically—copy of medical license, reference letters (for recertification), documentation of Continuing Medical Education (for recertification), etc. In addition, attestation forms to verify the data submitted electronically will also need to be printed out from the website, signed, and sent to the ABS.

As part of this change, the Preliminary Evaluation Form for the General Surgery Qualifying Examination (QE) has been integrated into the regular QE Application Form, eliminating the need for a separate form.

### Online Resident Rosters Are Here!

Beginning this January, program directors and coordinators can view and edit their resident rosters online via the ABS website. With this new function, program directors and coordinators are able to immediately update demographic information, addresses, and residency status. The new online process will make it easier for program directors and coordinators to maintain accurate resident roster information and help ensure that the ABS has the most up-to-date roster information for notifying graduating residents of the recertification application process.

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**2004 Important Dates**

- **March 8:** Online application process becomes available on the ABS website - www.absurgery.org
- **June 1:** Application deadline for General Surgery (GS) Recertification Examination
- **July 1:** “Late” application deadline for GS Recertification Examination (additional fee)

Visit www.absurgery.org for more important dates and information.

Stay tuned for future Technology Updates in ABS News!
Maintenance of Certification (cont.)

(Continued from Page 3) Under MOC, Continuing Medical Education (CME) will be required on a yearly basis (50 hours total, 30 of which must be Category I). Every third year, a personal (non-secure) self-assessment examination tool, such as the Surgical Education and Self-Assessment Program (SESAP) offered by the American College of Surgeons, must be completed by the diplomate. The ABS anticipates that other surgical societies and surgical textbook publishers will create self-assessment tools that also will satisfy this requirement. Reference letters verifying professional standing will also be required every third year as well as documentation of the three years’ CME and maintenance of a full and unrestricted medical license.

The criteria for the fourth component, evidence of evaluation of performance in practice, are still being defined; however, some form of practice assessment will be required of the diplomate five years into the ten-year cycle. Currently the ABS is considering the effectiveness of obtaining review of the surgeon’s practice from peers and referring physicians. It is hoped that objective outcomes data will become available in the future, as this would be the most effective way of validating practice results. Since no surgical specialty has yet settled on the ideal method for conducting practice evaluation, the requirements will evolve over time.

In addition, a secure recertification examination will be required at least every 10 years, as is the standard now. The more intensive CME requirements and the periodic self-assessment examinations of MOC will provide diplomates with a thorough preparation for the recertification examination; in addition, the possibility of weighting the recertification examination to the areas which primarily reflect a surgeon’s practice is being considered.

Surgeons who fail to provide the necessary documentation at the three-year interval will be given a warning at four years. If they fail to take corrective measures, their certification will expire at five years, rather than the normal ten-year cycle, and will only be reestablished by completing all MOC requirements and passing the secure recertification examination.

Additional information regarding MOC will be communicated to diplomates in the coming months to assist with the transition to this lifelong learning program.

ABS Welcomes New Board Members

The ABS said farewell to several members of the ABS Board of Directors who completed their terms in June 2003, and welcomed new board appointees at the January 2004 board meeting. The ABS sincerely thanks the following directors for years of dedicated service and counsel:

Mark A. Malangoni, M.D.
G. Patrick Clagett, M.D
Thomas M. Krummel, M.D.
Bradley M. Rodgers, M.D.
Luis O. Vasconez, M.D.

On this page and the next, you’ll find out more about our new directors. Welcome aboard!

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**Name:** E. Christopher Ellison, M.D., F.A.C.S.

**Birthplace:** Columbus, Ohio

**Family:** Wife Mary; Children Jonathan and Eric

**Hobbies:** Fly fishing, golf

**College:** University of Wisconsin

**Medical School:** Medical College of Wisconsin

**Residency:** The Ohio State University

**Clinical Fellowships:** Surgical Gastroenterology, The Ohio State University

**Research/Clinical Interests:** Pancreatic disease, wound healing, Zollinger-Ellison Syndrome

**Current Practice:** General Surgery

**Academic Appointment:** Professor and Chair Department of Surgery

**Administrative Titles:** Associate Vice President for Health Sciences and Vice Dean Clinical Affairs, Robert M. Zollinger Professor of Surgery

**Other Comments:** President, Ohio Chapter American College of Surgeons; Secretary, Central Surgical Association

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**Name:** Carlos A. Pellegrini, M.D.

**Birthplace:** Freye (Cordoba), Argentina

**Family:** Wife Kelly; Children Michael and John

**Hobbies:** Literature, music, aviation

**College:** University of Rosario, Argentina

**Medical School:** University of Rosario Medical School, Argentina

**Residency:** Rosario University Hospital, (Argentina), University of Chicago

**Clinical Fellowships:** Esophageal Physiology and Surgery, University of Chicago

**Research/Clinical Interests:** Physiology and pathophysiology of the esophagus. Management of esophageal diseases with focus on minimally invasive surgery

**Current Practice:** Upper gastrointestinal surgery, minimally invasive surgery

**Academic Appointment:** Henry N. Harkins Professor and Chairman, Department of Surgery, University of Washington

**Administrative Titles:** Chairman, Department of Surgery

**Other Comments:** Secretary of the American Surgical Association, Chair of the Digestive Disease Week Council, Regent of the American College of Surgeons
ABS Welcomes New Board Members (cont.)

Name: James A. Schulak, M.D.
Birthplace: Hammond, Indiana
Family: Wife Barbara; Children Andrew and Laura
Hobbies: Golf, art, reading
College: Brown University
Medical School: University of Chicago
Residency: University of Chicago
Clinical Fellowships: General Surgery, Clinical Transplantation, the University of Chicago Hospitals
Research/Clinical Interests: Ischemia/reperfusion injury in animal models; clinical transplant outcomes research.
Current Practice: Kidney, liver, and pancreas transplantation; surgery for pancreatic neoplasms and chronic pancreatitis.
Academic Appointment: Professor and Chairman, Dept. of Surgery, Case Western Reserve University School of Medicine
Administrative Titles: Chairman, Dept. of Surgery, Director of Abdominal Organ Transplantation, University Hospitals of Cleveland
Other Comments: Immediate past president of the American Society of Transplant Surgeons; past member of the UNOS Board of Trustees.

Name: Marshall Z. Schwartz, M.D.
Birthplace: Minneapolis, Minnesota
Family: Wife Michele; Children Lisa and Jeff
Hobbies: Traveling, woodworking, fishing
College: University of Minnesota
Medical School: University of Minnesota
Residency: University of Minnesota
Clinical Fellowships: Pediatric Surgery, Boston Children’s Hospital/Harvard Medical School
Research/Clinical Interests: Neonatal surgery; intestinal failure; chest wall deformities; renal transplantation. The role of growth factors in intestinal development, function and failure (IBD, SBS, ischemia-reperfusion injury).
Current Practice: Pediatric Surgery
Academic Appointment: Professor of Surgery and Pediatrics, Thomas Jefferson University, Philadelphia

Name: Thomas R. Stevenson, M.D.
Birthplace: Kansas City, Missouri
Family: Wife Judy; Children Anne and Andrew
Hobbies: Skiing, flying, dressage, bee keeping
College: University of Kansas
Medical School: University of Kansas
Clinical Fellowships: General Surgery, University of Virginia; Plastic Surgery, Emory University
Research/Clinical Interests: Reconstructive microsurgery, aesthetic surgery, ischemia/reperfusion injury
Current Practice: Plastic and Reconstructive Surgery
Academic Appointment: Professor and Chief, Division of Plastic Surgery, University of California, Davis
Administrative Titles: Chief, Division of Plastic Surgery, University of California, Davis

Name: Jonathan B. Towne, M.D.
Birthplace: Youngstown, Ohio
Family: Wife Sandy; Children Tim, Heidi and Christa
Hobbies: Woodworking, photography
College: University of Pittsburgh
Medical School: University of Rochester
Residency: University of Michigan, University of Nebraska
Clinical Fellowships: Vascular Surgery, Baylor University
Research/Clinical Interests: Long-term follow up of vascular grafts
Current Practice: Clinical vascular surgery
Academic Appointment: Professor and Chief Vascular Surgery, Medical College of Wisconsin
Administrative Titles: Chief of Vascular Surgery

2003 ABS Examination Statistics

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VS=Vascular Surgery, SCC=Surgery Critical Care, PS=Pediatric Surgery, HS=Hand Surgery, ITE=In-Training Exam, SBSE=Surgical Basic Science Examination
Q. How do I find a computer testing center near me to take the recertification exam?

A. A list of testing centers by state is available on Pearson VUE’s website, www.pearsonvue.com. As the centers have limited capacity, diplomates are encouraged to reserve a time and date to take the exam at a center near them as soon as they receive their exam admission letter from the ABS.

Q. With the new computer-based exams, will we know our results immediately after finishing the exam?

A. Instantaneous results are not feasible at this time for the computer-based exams as the ABS must conduct extensive statistical analyses to validate all exam questions and determine appropriate scoring standards. This process generally takes two to three weeks.

Q. Why can’t the recertification exams be “open book,” as with the recert exams given by some of the other ABMS boards?

A. Currently no ABMS boards will offer any exam in an open book format. The ABS believes a closed book format is essential to preserving the integrity of the examination process.

Q. What type of CME documentation is acceptable for the recertification exam application?

A. Copies of certificates from the primary source or sponsor of the educational activity are acceptable documentation. A list from the hospital/surgical center that clearly states that the activity is accredited by the ACGME or the American Medical Association is also acceptable.

Q. If the surgeon applying for the recertification exam is the chief of surgery and/or chairperson of the credentials committee, who should complete the reference forms?

A. The forms should then be filled out by a surgeon(s) of a comparable position at the institution, such as the chief of staff or medical director.

Q. Can a hospital surgical report be submitted instead of the ABS Operative Experience Report with the recertification exam application?

A. The ABS Operative Experience Report must be completed by the diplomate with all required signatures and submitted with the application.

For more FAQs, visit the ABS on the Web at www.absurgery.org