

**THE
AMERICAN BOARD
OF
THORACIC SURGERY**

BOOKLET OF INFORMATION

JANUARY 2010

Office of the Board
633 North St. Clair Street, Suite 2320
Chicago, Illinois 60611

**THE
AMERICAN BOARD
OF
THORACIC SURGERY**

BOOKLET OF INFORMATION

JANUARY 2010

Office of the Board
633 North St. Clair Street, Suite 2320
Chicago, IL 60611
(312) 202-5900
info@abts.org

THE AMERICAN BOARD OF THORACIC SURGERY
INCORPORATED 1950

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John C. Jones, M.D.*	1957-1959
O. Theron Clagett, M.D.*	1959-1961
Herbert C. Maier, M.D.*	1961-1963
John W. Strieder, M.D.*	1963-1965
Rollin A. Daniel, Jr., M.D.*	1965-1967
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Robert G. Ellison, M.D.	1979-1981
Benson B. Roe, M.D.	1981-1983
Donald G. Mulder, M.D.	1983-1985
Hassan Najafi, M.D.	1985-1987
Richard J. Cleveland, M.D.*	1987-1989
Harvey W. Bender, Jr., M.D.	1989-1991
Benson R. Wilcox, M.D.	1991-1993
John Ochsner, M.D.	1993-1995
William A. Gay, Jr., M.D.	1995-1997
Marvin Pomerantz, M.D.	1997-1999
Fred A. Crawford, Jr., M.D.	1999-2001
Peter C. Pairolero, M.D.	2001-2003
Timothy J. Gardner, M.D.	2003-2005
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Richard H. Feins, M.D.	2007-2009

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Richard H. Sweet, M.D.*	1952-1954
William E. Adams, M.D.*	1954-1955
John C. Jones, M.D.*	1955-1957
O. Theron Clagett, M.D.*	1957-1959
Herbert C. Maier, M.D.*	1959-1961
John W. Strieder, M.D.*	1961-1963
Rollin A. Daniel, Jr., M.D.*	1963-1965
Edward J. Beattie, Jr., M.D.*	1965-1967
David J. Dugan, M.D.*	1967-1969
Donald L. Paulson, M.D.*	1969-1971
Herbert Sloan, M.D.	1971-1973
C. Frederick Kittle, M.D.	1973-1973
Paul C. Adkins, M.D.*	1973-1975
Thomas B. Ferguson, M.D.	1975-1977
Robert G. Ellison, M.D.	1977-1979
Benson B. Roe, M.D.	1979-1981
Donald G. Mulder, M.D.	1981-1983
Hassan Najafi, M.D.	1983-1985
Richard J. Cleveland, M.D.*	1985-1987
Paul A. Ebert, M.D.*	1987-1989
Benson R. Wilcox, M.D.	1989-1991
John Ochsner, M.D.	1991-1993
William A. Gay, Jr., M.D.	1993-1995

Marvin Pomerantz, M.D.	1995-1997
Fred A. Crawford, Jr., M.D.	1997-1999
Peter C. Pairolero, M.D.	1999-2001
Timothy J. Gardner, M.D.	2001-2003
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William A. Gay, Jr., M.D.	2001-2003

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John C. Jones, M.D.*	1952-1959
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William M. Tuttle, M.D.*	1948-1962
Herbert C. Maier, M.D.*	1955-1963
Robert R. Shaw, M.D.*	1957-1963
Anthony R. Curreri, M.D.*	1958-1964
Henry T. Bahnson, M.D.*	1959-1965
Lyman A. Brewer, III, M.D.*	1959-1965
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Paul W. Sanger, M.D.*	1960-1966
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Francis X. Byron, M.D.*	1966-1968
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Duane Carr, M.D.*	1963-1969
Donald B. Effler, M.D.*	1963-1969
Denton A. Cooley, M.D.	1965-1971
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J. Gordon Scannell, M.D.*	1965-1971
Johann L. Ehrenhaft, M.D.*	1966-1972
Herbert Sloan, M.D.	1966-1973
Donald L. Paulson, M.D.*	1964-1973
Ralph D. Alley, M.D.*	1969-1975
C. Frederick Kittle, M.D.	1967-1975
Myron W. Wheat, Jr., M.D.	1969-1975
F. Henry Ellis, Jr., M.D.	1969-1976
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Harold C. Urschel, Jr., M.D.	1975-1982
Watts R. Webb, M.D.	1975-1982
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Philip E. Bernatz, M.D.	1977-1983
Benson B. Roe, M.D.	1971-1983
Frank C. Spencer, M.D.	1976-1983
Hermes C. Grillo, M.D.*	1978-1984
Quentin R. Stiles, M.D.	1978-1984
Harold V. Liddle, M.D.*	1979-1985
Donald G. Mulder, M.D.	1975-1985
Charles R. Hatcher, Jr., M.D.	1979-1986
Herbert Sloan, M.D.	1966-1986
Hassan Najafi, M.D.	1977-1987
H. Edward Garrett, M.D.*	1986-1987
John R. Benfield, M.D.	1982-1988
Richard M. Peters, M.D.*	1981-1988
W. Gerald Rainer, M.D.	1982-1988
W. Spencer Payne, M.D.*	1984-1988
Paul A. Ebert, M.D.*	1982-1989
Richard J. Cleveland, M.D.*	1979-1989
W. Gerald Austen, M.D.	1984-1990
Harvey W. Bender, Jr., M.D.	1983-1991
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Martin F. McKneally, M.D.	1985-1991
Andrew S. Wechsler, M.D.	1987-1993
Benson R. Wilcox, M.D.	1983-1993
L. Penfield Faber, M.D.	1986-1994
John Ochsner, M.D.	1986-1995
Mark B. Orringer, M.D.	1988-1995
John A. Waldhausen, M.D.	1989-1995
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Mortimer J. Buckley, M.D.*	1990-1996
Alden H. Harken, M.D.	1991-1996
William A. Gay, Jr., M.D.	1988-1997
James L. Cox, M.D.	1992-1998
Joseph I. Miller, Jr., M.D.	1991-1998

Gordon F. Murray, M.D.	1988-1998
J. Kent Trinkle, M.D.*	1992-1998
Marvin Pomerantz, M.D.	1989-1999
Floyd D. Loop, M.D.	1993-1999
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Fred A. Crawford, Jr., M.D.	1991-2001
David E. Hutchison, M.D. (Ad Hoc Member)	1996-2001
William A. Baumgartner, M.D.	1996-2002
Peter C. Pairolero, M.D.	1993-2003
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Irving L. Kron, M.D.	1998-2005
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Richard H. Feins, M.D.	1999-2009

*deceased

INTRODUCTION

The American Board of Thoracic Surgery (ABTS) publishes this Booklet of Information for prospective candidates for examination, and others who are interested, to outline the rules and regulations established by the Board in conformity with its policies. The Booklet is revised yearly.

The American Board of Thoracic Surgery does not publish a list of residency training programs in thoracic surgery, nor does it maintain a list of available openings in training programs. Institutions whose training programs are approved by the Residency Review Committee for Thoracic Surgery (RRC-TS) and accredited by the Accreditation Council for Graduate Medical Education (ACGME) are listed in the Graduate Medical Education Directory published annually by the American Medical Association or on the ACGME website. Only individuals who have successfully completed training in such programs will be admitted for examination.

The American Board of Thoracic Surgery is an active member of the American Board of Medical Specialties (ABMS). The Board also functions in close cooperation with the RRC-TS, and through it, with the ACGME and the Council for Medical Affairs. The Board also maintains close liaison with the Thoracic Surgery Directors Association (TSDA).

A list of Diplomates of the Board appears in *The Official American Board of Medical Specialties Directory of Board Certified Medical Specialists*.

Inquiries addressed to the American Board of Thoracic Surgery may be referred to one or more committees of the Board. Replies to such letters of inquiry may, therefore, be delayed for several weeks.

Address all communications to the Executive Director:

William A. Baumgartner, MD
Executive Director
American Board of Thoracic Surgery, Inc.
633 North St. Clair Street, Suite 2320
Chicago, Illinois 60611

HISTORY

Certification of thoracic surgeons was first discussed by the American Association for Thoracic Surgery (AATS) at its 1936 meeting in Rochester, Minnesota, but it was the consensus that no need for certification existed at that time. As a result of the rapid growth and importance of thoracic surgery as a specialty during the succeeding years, however, the need for a specialty board in thoracic surgery became apparent.

Recognizing that a large part of its membership wanted such a board, the AATS President in 1945 reappointed the original committee to study the matter. The committee's report at the 1946 AATS meeting, held in Detroit, prompted a recommendation that a Board of Thoracic Surgery be formed in affiliation with the American Board of Surgery (ABS).

An AATS committee was appointed to confer with a similar committee appointed by the ABS. The necessary steps with the Advisory Board of Medical Specialties were accomplished, and at the AATS meeting, held in St. Louis in May 1947, the committee's report was submitted and adopted unanimously.

Through negotiations, a plan of organization was worked out and approved by the ABS and AATS at their respective meetings in Quebec in 1948. The organization of the Board of Thoracic Surgery was structured in accordance with the provisions of the plan, and the first, or organizational, meeting was held in Detroit on October 2, 1948.

On January 1, 1971, the Board of Thoracic Surgery became a primary board and changed its name to the American Board of Thoracic Surgery. It is a member of the ABMS, which encompasses twenty-four specialties with primary Boards. The purpose of these Boards is to certify physicians who have completed an ACGME approved residency in a specialty, and, through their Maintenance of Certification (MOC) programs, promote lifelong learning and practice improvement. These processes have been instituted in the public interest.

ORGANIZATION OF THE BOARD

The Board consists of seventeen Directors nominated from the organizations listed below, and the Executive Director who is nominated at-large:

The American Association for Thoracic Surgery	4
The Society of Thoracic Surgeons	4
The American Surgical Association	2
The American College of Surgeons	2
The Thoracic Surgery Directors Association	2
The American Medical Association	1
The American Board of Surgery	1
Executive Director, at-large	<u>1</u>
Total Membership	17

Each cooperating organization selects nominees, and the Board elects Directors judged to be the best suited to meet its current needs. The term of each Director is six years.

PURPOSE AND FUNCTIONS OF THE BOARD

The primary purpose and most essential function of the Board are to protect the public by establishing and maintaining high standards in thoracic surgery. To achieve these objectives, the Board has established qualifications for examination and procedures for certification and Maintenance of Certification. The requirements and procedures are reviewed regularly and modified as necessary.

Board certification in a medical specialty is evidence that a physician's qualifications for specialty practice are recognized by his or her peers. It is not intended to define the requirements for membership on hospital staffs, to gain special recognition or privileges for its Diplomates, to define the scope of specialty practice, or to state whom may or may not engage in the practice of the specialty. Specialty certification of a physician does not relieve a hospital's governing body from responsibility in determining the hospital privileges of such specialist.

The Board does not use or sanction the terms "board eligible" or "board qualified." The Board does not consider any physician to be a candidate for examination until he or she has made formal application and has been accepted for examination. Acceptance for examination acknowledges only that the candidate has successfully fulfilled the requirements and does not recognize that he or she is a specialist in thoracic surgery.

DEFINITION OF THORACIC SURGERY

Thoracic Surgery encompasses the operative, perioperative, and surgical critical care of patients with acquired and congenital pathologic conditions within the chest. Included are the surgical repair of congenital and acquired conditions of the heart, including the pericardium, coronary arteries, valves, great vessels and myocardium. It also includes pathologic conditions of the lung, esophagus and chest wall, tumors of the mediastinum, and diseases of the diaphragm and pericardium. Management of the airway and injuries to the chest are also within the scope of the specialty.

CLINICAL COMPETENCE IN THORACIC SURGERY

Clinical competence in thoracic surgery requires factual knowledge and technical skills in the preoperative evaluation, operative management, and postoperative care of patients, including critical care, with pathologic conditions involving thoracic structures. Precise definition of the scope of thoracic surgery as well as the current methods used to assess education, knowledge and experience have been developed to ensure that an individual who is certified by the American Board of Thoracic Surgery has met certain standards and qualifications.

The scope of thoracic surgery encompasses a knowledge of normal and pathologic conditions of both cardiovascular and general thoracic structures. This includes congenital and acquired lesions (including infections, trauma, tumors, and metabolic disorders) of both the heart and blood vessels in the thorax, as well as diseases involving the lungs, pleura, chest wall, mediastinum, esophagus, and diaphragm. In addition, the ability to establish a precise diagnosis, an essential step toward proper therapy, requires familiarity with diagnostic procedures such as cardiac catheterization, angiography, electrocardiography, echocardiography, imaging techniques, endoscopy, tissue biopsy, and biologic and biochemical tests appropriate to thoracic diseases. It is essential that the thoracic surgeon be knowledgeable and experienced in evolving techniques, such as laser therapy, endovascular procedures, electrophysiologic procedures and devices, circulatory support, thoracoscopy and

thoracoscopic surgery. Thoracic surgeons receive education and experience in the critical care of patients with cardio-thoracic diseases, as an integral part of residency.

The factual knowledge and technical skills necessary to treat patients with thoracic conditions are obtainable in a thoracic surgery residency program that is approved by the RRC-TS and accredited by the ACGME. The highest educational standards are best achieved in residency programs in which close supervision and instruction as well as progressive individual responsibility for operative and postoperative care are possible.

The American Board of Thoracic Surgery realizes that an examination primarily tests the ability to reason and the factual knowledge acquired by the candidate. The limitations of examinations alone to assess clinical competence are well recognized, and an important part of the responsibility for determining clinical competence rests upon the director of each thoracic surgery residency program. It is for this reason that only applicants who complete an accredited thoracic surgery residency program will be considered for examination. It is during the period of residency that the trainee's ethical and moral character, judgment, technical skills, and abilities to cope with a wide variety of clinical problems can be assessed most accurately. Thus, the endorsement of the candidate by the Program Director is required to complete eligibility for certification by the American Board of Thoracic Surgery.

Following the completion of residency in an accredited program, written and oral examinations are given to assess the trainee's capabilities. These examinations are constructed and given annually by the American Board of Thoracic Surgery. Consultation and assistance in developing the examinations and analyzing the results are obtained from psychometricians and other experts. The validity and reliability of the examination process are scrutinized continually. To enter the examination process, candidates must submit to the ABTS office an application that includes the specifics of their thoracic surgical operative experience in residency and the signature of the Program Director indicating satisfactory completion of the residency program. A passing score on the examination acknowledges that the candidate possesses a broad knowledge base that is necessary to be clinically competent in thoracic surgery.

The current methods for establishing the candidate's qualifications are reviewed periodically and revised, when appropriate, in a continuing effort to assure the public that thoracic surgeons certified by the American Board of Thoracic Surgery have been adequately educated in and are competent to practice the specialty.

GENERAL REQUIREMENTS

Certification by the American Board of Thoracic Surgery may be achieved by completing one of the following four pathways and fulfillment of specific requirements:

1. Pathway One is the successful completion of a full residency in General Surgery approved by the ACGME, followed by the successful completion of an ACGME-approved Thoracic Surgery residency. Successful completion of a 4/3 General Surgery/Thoracic Surgery Joint Training Program approved by the ACGME fulfills the requirements of Pathway One.

Pathway Two is the successful completion of a full residency in General Surgery or Cardiac Surgery approved by the Royal College of Physicians and Surgeons of Canada, followed by the successful completion of an ACGME-approved Thoracic Surgery residency.

Pathway Three is the successful completion of a six-year integrated Thoracic Surgery residency developed along guidelines established by the TSDA and approved by the ACGME (RRC-TS).

Pathway Four is the successful completion of an ACGME-approved Vascular Surgery residency that can lead to primary certification followed by the successful completion of an ACGME-approved Thoracic Surgery residency.

These pathways must provide adequate education and operative experience in cardiovascular and general thoracic surgery.

2. An ethical standing in the profession and a moral status in the community that are acceptable to the Board.
3. A satisfactory performance on the American Board of Thoracic Surgery examinations.
4. A currently registered full and unrestricted license to practice medicine granted by a state or other United States jurisdiction. The license must be valid at the time of application for admission to examination and maintained until certified by the ABTS. A temporary, limited license such as an educational, institutional, or house staff permit is not acceptable to the Board, unless the candidate is currently enrolled in a subspecialty residency approved by the ACGME. Candidates for certification are required to notify the Board if any restrictions are placed on their license during the certification process.
5. For residents who began their Thoracic Surgery residency in July 2003 and after, certification by the ABS is optional rather than mandatory.

RESIDENCY REQUIREMENTS

Candidates must have fulfilled all of the American Board of Thoracic Surgery residency requirements that are in force at the time their applications are received.

Candidates for certification must complete a minimum of 24 months of residency training in thoracic and cardiovascular surgery in a program accredited by the RRC/TS. This must include 12 months of continuous senior responsibility. These requirements also pertain to the 6-year integrated residency programs. The director of the thoracic training program is required to approve the application form by signature, certifying that the candidate has satisfactorily completed the residency in thoracic surgery as described above. Once an application is received, it is considered the official and only record. The Board assumes that the appropriate signatures authenticate the accuracy of the case lists and all other information submitted on the application.

Education and adequate operative experience in both general thoracic surgery and cardiovascular surgery are essential parts of any approved thoracic surgery residency program, irrespective of the area of thoracic surgery in which a candidate may choose to practice.

OPERATIVE CASE CRITERIA

The operative experience requirement of the American Board of Thoracic Surgery has two parts. One is concerned with the intensity or volume of cases, and the other with the distribution of cases (index cases).

1. Surgical Volume (Intensity)

The Board's operative experience requirements include an annual average of 125 major operations performed by each resident based on the following lengths of training programs:

- 2-year programs: 125 major operations for each year, for a total of 250 major cases;
- 3-year programs: 125 major operations for each year, for a total of 375 major cases;
- 4/3 joint training programs: 125 major operations for the last two years of training, for a total of 250 major cases;
- 6-year programs: 125 major operations for the last three years of training, for a total of 375 major cases

This guideline on intensity of cases conforms with the Program Requirements in Thoracic Surgery as published by the ACGME and the RRC-TS.

The application of any candidate whose supervised operative experience fails to meet the requirement of an annual average of 125 major operations with a minimal number of 100 in any one year will be referred to the Board's Credentials Committee for review.

2. Index Cases (Distribution)

Index Cases are Full Credit Cases only. Index cases are defined as the resident being the primary surgeon. They do not include first assistant cases, unless specifically stated.

The application of a candidate whose operative experience does not include the required number of index cases as listed below will be sent to the Credentials Committee for review.

Index Cases

For Residents who started their training on or after July 1, 2007

Residents who started their training on or after July 1, 2007, can choose either the General Thoracic Pathway or the Cardiothoracic Pathway. Resident must meet the operative numbers entirely from one pathway. The number of index cases required to meet the minimal acceptable standards in the various areas are:

General Thoracic Pathway

	<u>Total Number</u>
Congenital Heart Disease	10
<i>The 10 cases can be either Primary or First Assistant</i>	
Adult Cardiac	75
Acquired Valvular Heart	20
Myocardial Revascularization	40
Re-Operations	5*
Aorta	0
Other	15
Lung, Pleura, Chest Wall	100
Pneumonectomy, lobectomy, segmentectomy	50
Other	50
Mediastinum (resection)	10
Esophagus	30
Esophagectomy/Resection	20
Benign esophageal disease	5
Other	5
VATS	30
Total Major Cases	255
Endoscopy	90
Bronchoscopy	40
Esophagoscopy	25
Mediastinoscopy	25
Consultative Experience	100
New Patients	50
Follow-up	50

Cardiothoracic Pathway

Congenital Heart Disease	20
Primary	10
First Assistant	10
Adult Cardiac	150
Acquired Valvular Heart	50
Myocardial Revascularization	80
Re-Operations	15*
Aorta	5
Other	15

Lung, Pleura, Chest Wall		50
Pneumonectomy, lobectomy, segmentectomy	30	
Other	20	
Mediastinum (resection)		5
Esophagus		15
Esophagectomy/Resection	10	
Benign esophageal disease/Other	5	
VATS		15
Total Major Cases		255
Endoscopy		40
Bronchoscopy	20	
Esophagoscopy	10	
Mediastinoscopy	10	
Consultative Experience		100
New Patients	50	
Follow-up	50	

For Residents who started their training before July 1, 2007

Congenital Cardiac		20
Full Credit	10	
First Assistant	10	
Adult Cardiac		75
Acquired valvular heart	20	
Myocardial revascularization	40	
Other	15	
Re-operations	5*	
Lungs, pleura, chest wall		50
Pneumonectomy, lobectomy, segmentectomy	30	
Other	20	
Esophagus, mediastinum, diaphragm		15
Esophageal operations	8	
Resections	4	
Other esophageal	4	
Other	7	
Bronchoscopy and esophagoscopy		30
(Must include at least 10 esophagoscopy.)		
VATS		10

Endoscopic procedures may be counted for credit whether they are performed as independent procedures or immediately preceding a thoracic operation.

*Re-operation procedures can be counted twice for any adult cardiac procedure. For example, a redo coronary artery bypass surgery may be counted as both a myocardial revascularization and a re-operation.

VATS procedures may be counted twice, once as a major procedure and again as a VATS procedure. For example, a Lobectomy with VATS can be counted as a Lobectomy and as a VATS.

Major vascular operations outside the thorax and procedures, such as pacemaker implantation and closed electrophysiology procedures, would be under Adult Cardiac-Other and should be separately listed.

The Board recognizes that supervised operative experience in a well-organized teaching setting that is approved by the RRC-TS protects the patient, who, in most instances, is the personal and identifiable responsibility of a faculty surgeon. This supervised experience optimally prepares the candidate to begin the independent practice of cardiothoracic surgery after the completion of residency.

The Credentials Committee has been authorized by the Board to reject a candidate if his or her operative experience during the thoracic surgery residency is considered to be inadequate. The candidate, the Program Director, and the RRC-TS will be notified if such action is taken. If the Credentials Committee finds the applicant's operative experience inadequate and additional training is required, **the additional training must be approved by the Board in advance.** Should the Program Director determine that a resident needs additional training beyond the number of years that have been approved by the ACGME and the RRC-TS, before submitting an application, **this additional training must also be approved by the Board in advance.**

Even though emphasis on one or another facet of thoracic surgery (pulmonary, cardiovascular, esophageal, thoracic trauma, etc.) may have characterized a candidate's residency experience, the candidate is nevertheless held accountable for knowledge concerning all areas of the field, including extracorporeal perfusion (physiological concepts, techniques, and complications), cardiac assist devices, endovascular techniques, management of dysrhythmias, thoracic oncology and VATS. In addition, a candidate should have had responsibility for the care of pediatric cardiac patients. The candidate should also have an in-depth knowledge of the critical care of acutely ill patients in the intensive care unit. This requires an understanding of cardiorespiratory physiology, circulatory assist devices, respirators, blood gases, metabolic alterations, cardiac output, hyperalimentation, and many other areas.

OPERATIVE EXPERIENCE CREDIT

Full credit will be allowed for supervised operative experience in a well-organized teaching setting only when the following criteria are met:

- a. The resident participated in the diagnosis, preoperative planning, surgical indications, and selection of the appropriate operation;
- b. The resident performed, under appropriate supervision in a well-organized teaching setting approved by the RRC-TS, those technical manipulations that constituted the essential parts of the procedure itself;

- c. The resident was substantially involved in postoperative care including critical care.

Supervision and active participation by the thoracic surgery faculty are required in preoperative, intraoperative, and postoperative care.

The Board also emphasizes that first-assisting at operations is an important part of resident experience, particularly in complex or relatively uncommon cases.

APPLICATIONS

Before applying for examination, prospective candidates should consider whether they are able to meet the minimum requirements of the Board. All residents must meet the operative case requirements as listed in this booklet and which are available on the Board's web site at www.abts.org.

Residents are required to use the online application within the CTSNet Op Log functions. Directions for utilizing the online application should be carefully followed since some of the forms must be printed from the web site, signed by the the Resident and the Thoracic Surgery Program Director and sent to the Board office with a copy of the medical license and the registration fee. A list of the documents that must be submitted with the online application is available on the web site. A copy of the resident's valid license to practice medicine must be included with the application materials.

The operative case logs are considered the property of the resident and are not kept in the Board office once the resident is certified. **All fields of the Op Log should be completed including date, patient ID or case number, diagnosis, title of the operation, and outcome.**

When the resident is ready, the draft online application is reviewed by the Program Director. Once he/she approves the application, the Program Director submits it online to the Board office. The application that is submitted is considered a final document. An incomplete or incorrectly completed application may delay processing for one year. Residents are encouraged to address questions regarding the American Board of Thoracic Surgery requirements to their Program Director.

The deadline for submitting the completed application is August 15. Failure to meet that deadline may result in a delay of at least one year. Candidates are notified of their eligibility for examination when their applications have been approved.

The American Board of Thoracic Surgery takes particular note of the problems facing those with a disability and stands ready to alter its examination procedures in such a way that candidates who are competent to practice thoracic surgery have the opportunity to take the Board's examination under circumstances that accommodate the individual's disability. Individuals requiring special consideration because of a disability should notify the Board at least 60 days before the August 15 deadline for submitting an application.

EXAMINATIONS

The Board's policy is to consider a candidate for examination only after he or she has successfully completed a thoracic surgery residency program approved by the RRC-TS and the ACGME.

Separate written and oral examinations are held annually at times and places determined by the Board. Information regarding the dates and places of the examinations is published in the *Journal of Thoracic and Cardiovascular Surgery* and the *Annals of Thoracic Surgery* and on the ABTS web site (www.abts.org).

The 2010 Part II (oral) examination will be held on June 11 and 12, 2010 in Chicago.

The 2010 Part I (written) examination is scheduled for November 22, 2010. The examination will be given in an electronic format at Pearson Professional Testing Centers located throughout the United States.

PART I Written Examination

The examination consists of a written examination designed primarily to assess cognitive skills. The content of the questions on this examination represents uniform coverage of all aspects of the thoracic surgery specialty, including adult cardiac, congenital cardiac, general thoracic, and cardiothoracic critical care. A list of the exam content can be found on the Board's web site.

PART II Oral Examination

Successful completion of the Part I (written) examination is a requirement for admission to the Part II (oral) examination. The oral examination is designed to test the candidate's knowledge, judgment, and ability to correlate information in the management of clinical problems in general thoracic and cardiovascular surgery. Candidates are expected to be proficient in adult cardiac, congenital cardiac, general thoracic and cardiothoracic critical care.

EXAMINATION SEQUENCE

Candidates need to apply for the examination within 5 years of the satisfactory completion of their thoracic surgery residency. Any candidate applying for the examination five years or more after the satisfactory completion of residency will be considered individually by the Credentials Committee. To be eligible, any recommended additional training must be completed before an application can be submitted.

After a candidate is declared eligible for the written examination (Part I), he or she must pass Part I within 4 years. The candidate who successfully completes Part I of the examination then must pass Part II within the succeeding 4 years.

Candidates who fail an examination (Part I or Part II) are eligible to repeat the examination the following year.

Candidates who fail either Part I or Part II of the examination three times, or do not pass either part of the examination within the allotted time period of four years, will be required to complete an additional thoracic surgical educational program **which must be approved in advance** by the Board before they will be permitted to retake the examination. The required additional training must be completed within the succeeding 2-year period after failing either the written or the oral examination. Candidates who complete the required additional training must have their eligibility for examination reviewed by the Executive Director and/or the Credentials Committee. Candidates will be given two more opportunities to take the examination (Part I or Part II) within the succeeding two years.

Candidates who fail either Part I or Part II a fifth time will be required to complete another approved thoracic surgery residency before they will be eligible to re-apply for examination by the Board.

FEES

2010 Registration fee (not refundable)	\$ 475.00
2010 Part I Examination fee	\$ 1,225.00
2010 Part I Re-Examination fee	\$ 1,225.00
2010 Part II Examination fee	\$ 1,500.00
2010 Part II Re-Examination fee	\$ 1,500.00

Applications that have postmarks later than August 15 will not be accepted.

Candidates who do not appear for their scheduled examination (Part I or Part II) or who cancel less than six weeks prior to either examination may forfeit their examination fee.

The Board is a non-profit corporation, and the fees from candidates are used solely to defray actual expenses incurred in conducting examinations and carrying out the business of the Board. The Directors of the Board serve without remuneration.

APPEALS

Individuals who receive an unfavorable ruling regarding their applications from a committee of the Board may appeal such determination by mailing a notice of appeal to the office of the American Board of Thoracic Surgery within 45 days of the date such ruling was mailed. A copy of the appeals procedure will be mailed to the candidate or can be found on our website at www.abts.org.

Individuals who are in the written exam process may only request reconsideration regarding potential fraud, misconduct or irregularities. There is no appeal for the content of the examination, the sufficiency or accuracy of the answers given, scoring of the examination, nor any other matter. Any individuals who wish to seek reconsideration on the basis of fraud, misconduct or irregularities may immediately upon conclusion of the written examination, and in any event no later than 7 days following the written examination, request that the Board allow him or her to retake the examination at no additional cost.

Individuals in the oral exam process who believe that any of the examiners have been unfair or biased during portions of the oral examination may immediately upon conclusion of the examination request of the Executive Director of the Board a reexamination by another examiner using different case protocols covering similar subject matter. If the Executive Director and the other Officers determine that there are reasonable grounds, the individual shall be reexamined immediately by a Board member. In such instances, only the score given by the re-examiner will be considered.

CHEMICAL DEPENDENCY

Qualified applicants who have a history of chemical dependency that has been reported to the Board and who submit documentation suitable to the Board that their dependency has been under control for a period of at least two years will be admitted to the examination process.

For candidates who are already in the examination process and develop a chemical dependency as reported to the Board, the process will be suspended until the candidate can

provide documentation suitable to the Board that the condition has been under control for a period of two years. At that time, the candidate will be readmitted to the examination process. The requirement to be accepted for examination within five years of completion of an approved thoracic surgery residency will not be waived.

CERTIFICATION

After a candidate has met the requirements for eligibility and passed the examination, a certificate attesting to the candidate's qualifications in thoracic surgery will be issued by the Board. The certificate is valid for 10 years.

MAINTENANCE OF CERTIFICATION

Applicants who are certified in thoracic surgery are issued certificates that are valid for 10 years from the date of certification, after which the certificates will no longer be valid. Certificates can be renewed before expiration by fulfilling the requirements for Maintenance of Certification (MOC) specified by the American Board of Thoracic Surgery at that time. A MOC Booklet is available on the Board's web site at www.abts.org.

ANNUAL MAINTENANCE OF CERTIFICATION FEE

An annual MOC Fee is required of all Diplomates except those who are retired and/or disabled. The fee, which is cumulative, is not assessed to Diplomates in the year of their certification. The Board will not respond to inquiries about the Diplomate's certification status until the fee is paid each year. Diplomates must be current with the annual fee in order to participate in the MOC process.

DENIAL OR REVOCATION OF CERTIFICATE

No certificate shall be issued or a certificate may be revoked by the Board if it determines that:

- a. the candidate for certification or Diplomate did not possess the required qualifications and requirements for examination, whether such deficiency was known to the Board or any Committee thereof before examination or at the time of issuance of the certificate as the case may be;
- b. the candidate for certification or Diplomate withheld information in his or her application or made a material misstatement or any other misrepresentation to the Board or any Committee thereof, whether intentional or unintentional;
- c. the candidate for certification or Diplomate was convicted by a court of competent jurisdiction of any felony or misdemeanor involving moral turpitude and, in the opinion of the Board, having a material relationship to the practice of medicine;
- d. the candidate for certification or Diplomate had his or her license to practice medicine revoked or was disciplined or censured by any court or other body having proper jurisdiction and authority because of any act or omission arising from the practice of medicine; or
- e. the candidate for certification or Diplomate had a history of chemical dependency or developed such during the certification process and failed to report same to the Board.

Revised January 2010