subspecialty practice more important. Clearly, both approaches are considered valid by other Boards and by the ABMS. The current ABTS approach of a comprehensive exam derived from SESATS has been associated with a high pass rate and general approval from diplomates. The ABTS will continue to consider the validity of the two approaches but has also been advised by our psychometrician to gain further experience with the comprehensive exam before considering any change. If undertaken, transition to a modular exam would require a much larger pool of exam questions with subspecialty-focused questions of far greater difficulty than used currently.

CONGENITAL CARDIAC SURGERY SUBSPECIALTY CERTIFICATION

After several years of development leading to approval by the ABMS of a subspecialty certificate in Congenital Cardiac Surgery, the ABTS initiated the certification examination process in 2009. Two pathways currently permit certification in Congenital Cardiac Surgery, which can be obtained only after primary ABTS certification. "Pathway One" is the successful completion of a full

congenital cardiac surgery residency approved by the ACGME, starting on July 1, 2008 or thereafter. "Pathway Two" is for those candidates who trained before July 1, 2008. Admission into the subspecialty certification process is based on training, current clinical experience, and professional accomplishments in the field. This pathway remains in effect only until 2014. To date, 3 candidates have obtained certification via Pathway One and 92 candidates completed certification via Pathway Two. The process of MOC for Congenital Cardiac Surgery is now in development.

Rapid evolution in the practice of Thoracic Surgery during the past decade, new requirements for MOC, and problems in residency training have required the ABTS to become intimately involved in these areas because they affect certification in the specialty. A collaborative approach with the RRC-TS, JCTSE, TSDA, and ABS has been essential to addressing these challenges. As physicians in general come under increasing administrative oversight, continued dynamic involvement of the ABTS and regular reappraisal of the certification process is key to supporting the well-being of our specialty.

COMMENTARY

The ethical dilemma of Thoracic Surgery recertification

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As stated in the published documents of the American Board of Thoracic Surgery (ABTS), "The primary purpose and most essential function of the Board is to protect the public by establishing and maintaining high standards in thoracic surgery."¹ Few would disagree that for initial certification, the ABTS has been successful. Indeed, in the current ABTS update published in this journal,² the authors have outlined continuing process improvements,

including alternate pathways to certification, revised case requirements that more accurately reflect current practice, and improved examination strategies. By all measures, ABTS initial certification of competency to the American public of an applicant, who has completed the necessary training and passed the current examination, to independently practice both general thoracic and cardiovascular branches of our specialty is accurate. However, I am not certain that the same degree of accuracy applies to recertification of all applicants who successfully complete the current ABTS Maintenance of Certification (MOS) process.

For example, in accordance with the requirement for recertification every 10 years, I applied for and was recertified by the American Board of Thoracic Surgery in 1987, 1997, and 2005 after fulfilling the requirements

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established in 1983, namely, each time submitting evidence of attendance at appropriate continuing medical education functions, a practice review of recent surgical results, and completion and passing of the Self-Education/Self-Assessment in Thoracic Surgery (SES-ATS) examination. At that point I would argue that my recertification as being competent to independently practice both cardiovascular and general thoracic surgery was in some ways deceiving, for I had not performed 1 general thoracic surgical procedure since joining the cardiac surgical staff at the Massachusetts General Hospital in 1977.

The updated process of recertification, adopted in 2008 and which is gradually being implemented, will be much more rigorous than in previous years, as noted in ABTS published documents.³ However, the goal of MOS remains recertification that an applicant is competent to practice the entire gamut of general thoracic and cardiovascular surgical treatments and procedures. (My concern is *not* with surgeons who have consistently practiced both components of the specialty during the time between certification and recertification. The MOS process is appropriate for them.)

Rusch and colleagues in their update² admit that there are differing points of view about the appropriateness of administering comprehensive versus modular examinations for recertification, ie testing and recertifying candidates on the entire spectrum of general thoracic and cardiovascular surgery versus a focus on the subspecialization that a candidate may actually practice. I submit that the latter is the more honest and ethical approach.

Were we solely a cognitive specialty, a comprehensive recertification process might be appropriate; but we are surgeons. As initial certification in our specialty extends to affirming that we are familiar with and technically competent to perform the operative procedures that define our specialty, so should recertification affirm to the public that we remain technically competent in those areas for which we are recertified. Of note, Canada and several other countries have separate certification boards for cardiac and

general thoracic surgery, but few of them have as formal a recertification policy as the ABTS. While the ABTS can claim leadership in maintenance of certification, American thoracic surgeons are not leaders in modular assessment.

I am concerned with the ethical issue posed by recertifying someone as being competent in both cardiac and general thoracic surgery when that surgeon has focused on only 1 branch of our specialty, or even further subspecialization in congenital heart surgery. I fear that in the case of recertification the American Board of Thoracic Surgery has not been as forward thinking as it has with initial certification. In my view the MOS process is not consistent with quality assurance, “truth in lending,” or transparency—current politically correct expressions concerning honest representation of competence.

The fact that most hospitals have in more recent years adopted much more detailed systems for procedural privileging does not absolve the ABTS from facing this ethical issue of globally recertifying many cardiac and general thoracic surgeons whose surgical practice has become focused on 1 branch of our specialty.

As medicine is being increasingly assailed for its lack of honesty, including issues of conflict of interest, failure to censure incompetent practitioners, and lack of public reporting of results, one can imagine that processes of recertification will soon be exposed to enhanced scrutiny by outside reviewers. The ABTS would do well to reconsider the MOS process and become proactive in changing the goal of recertification, which means that for many surgeons their recertification would be limited to cardiovascular or general thoracic surgery. That would be the ethical thing to do.

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