Ten specialty boards report accomplishments and plans:

Part II

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the *Bulletin* to keep Fellows abreast of any changes in the procedures of the various boards. The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the *Bulletin* contains the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, the American Board of Surgery, and the American Board of Urology.

The March issue of the *Bulletin* featured the reports of the American Board of Neurological Surgery, the American Board of Orthopaedic Surgery, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Thoracic Surgery.

American Board of Colon and Rectal Surgery

by Herand Abcarian, MD, FACS, Chicago, IL

Past and future meetings

The American Board of Colon and Rectal Surgery (ABCRS) held its most recent annual meeting September 22, 2002, and its most recent interim meeting March 24, 2002, in Chicago, IL. Future meetings and examinations were scheduled be held in Chicago through 2005. The schedule is as follows:

Written examination/ interim meeting	**Oral examination/ annual meeting**
March 22-23, 2003	September 19-21, 2003
March 20-21, 2004	October 1-3, 2004
March 19-20, 2005	September 23-25, 2005

Officers and members of the board

The board is composed of 14 members. Nominations to fill vacancies are from the board and five other sponsoring organizations. The ABCRS nominates four members; the American Society of Colon & Rectal Surgeons (ASCRS) nominates four; the American College of Surgeons nominates two; the American Medical Association nominates one; the Association of Program Directors for Colon and Rectal Surgery (APDCRS) nominates two; and the American Board of Surgery nominates one. Board members normally serve two four-year terms, a total of eight years.

The board's current officers are: Robert D. Fry, MD, FACS, president; James W. Fleshman, MD, FACS, vice-president; and Herand Abcarian, MD, FACS, executive director (at pleasure of the board). Current members of the board are: Richard P. Billingham, MD, FACS; Terry C. Hicks, MD, FACS; Vendie H. Hooks, MD, FACS; Ian C. Lavery, MD, FACS; Martin A. Luchtefeld, MD, FACS; Robert D. Madoff, MD, FACS; Patricia L. Roberts, MD, FACS; John P. Roe, MD, FACS; Alan G. Thorson, MD, FACS; Marshall M. Urist, MD, FACS; and Bruce G. Wolff, MD, FACS.

The board is pleased to announce that at its September 22, 2002, meeting, Drs. Billingham, Hooks, and Roe were re-elected and are serving their second four-year terms.

Proposal to increase board membership

At the September 22, 2002, meeting, the board voted to increase its membership from 12 to 14 members. The decision was reached because it has become increasingly difficult for the board to carry out its internal responsibilities, as well as to meet its demanding outside obligations, with 12 board members. The ABCRS and the APDCRS were each designated to provide an additional member, bringing ABCRS representation up to four members and the APDCRS up to two members. Filling the new slots were Dr. Luchtefeld, the new APDCRS representative, and Dr. Roberts, the new ABCRS representative.

Associate examiners

The board maintains a slate of associate examiners whose terms rotate at different intervals. Currently there are 16 associate examiners: Marcus J. Burnstein, MD, FACS; Charles P. Orsay, MD, FACS; W. Donald Buie, MD, FACS; Janice F. Rafferty, MD, FACS; Jose R. Cintron, MD, FACS; Jan Rakinic, MD, FACS; Richard M. Devine, MD, FACS; Thomas E. Read, MD, FACS; Brett T. Gemlo, MD, FACS; Clifford L. Simmang, MD, FACS; Tracy L. Hull, MD, FACS; Michael J. Stamos, MD, FACS; Neil H. Hyman, MD, FACS; Mark L. Welton, MD, FACS; Ann C. Lowry, MD, FACS; and Richard L. Whelan, MD, FACS.

Five associate examiners completed their terms this September, and the board is grateful for their excellent service. They will be placed in the ranks of senior examiners and periodically invited to serve in the oral examination process. They are: P. Sue Beckwith, MD, FACS; Theodore J. Saclarides, MD, FACS; Frank J. Harford, MD, FACS; Judith L. Trudel, MD, FACS; and Bruce A. Orkin, MD, FACS.

Table 1. ABCRS - Recertification performance: 1998 - 2000

Year	Participants	Passed	%	Failed	%	Maximum	Minimum	Average
2002	43	42	98%	1	2	94%	59%	82%
2001	24	23	96	1	4	90	69	81
2000	16	13	81	3	19	90	59	80
1999	68	62	91	6	9	94	61	82
1998	46	44	96	2	4	93	57	81
Total	197	184	93	13	7	Passing score: 70 Percent		

Table 2. Examination results: Pass/fail rates

	Written exam - March 23, 2002 (65 candidates)					Oral exam - September 21, 2002 (70 candidates)				
	#	Fail rates	%	Pass rates	%	#	Fail rates	%	Pass rates	%
Total candidates	65	10/65	15	55/65	85	70	13/70	19	57/70	81
First-time takers	56	5/56	9	51/56	91	50	6/50	12	44/50	88
Repeat candidates	9	5/9	56	4/9	44	20	7/20	35	13/20	65

Table 3. Geographic/gender distribution

Total current diplomates	Male	%	Female	%	All	%
Active U.S.	1,009	72.90	106	7.66	1,115	80.56
Active international	66	4.77	5	0.36	71	5.13
Retired U.S.	184	13.29	2	0.14	186	13.44
Retired international	5	0.36	0	0.00	5	0.36
Status/address unknown	5	0.36	0	0.00	5	0.36
Expired certificate holders	2	0.14	0	0.00	2	0.14
Total	1,271	91.84	113	8.16	1,384*	100.00

*This figure excludes diplomates who are deceased.

Examination committee activities

The ABCRS oral examination committee, under the direction of Dr. Hicks, is focusing its attention on standardizing the oral examination process. Its goal is to change the oral examination from one that merely tests candidates' recall knowledge to one that tests their cognitive knowledge. The committee began this task by editing existing oral case scenarios, making all the options clear, focused, and consistent. The process requires all examiners to test on the same material and to gather responses in key elements from each can-

didate. The intention is to make the oral process more objective and to provide a mechanism that will better identify the areas in which candidates fail.

Thirty-eight cases were preselected for this year's oral examination, 19 for the morning session and 19 for the afternoon session. Photos and line drawings were also added. In general, the new process was well accepted and well executed by examiners. This year's failure rate was 19 percent, compared with 22 percent in 2001. The decrease cannot be attributed to the new process, but future failure rates will be compared to previous examinations. New case scenarios will be added in 2003 and some format changes will be made.

Recertification activities

The last recertification examination was given June 4, 2002, in Chicago. Forty-three diplomates participated; 42 passed and one failed. The results and statistical summaries for the last five years are provided in Table 1 on page 39.

Examination results

The most recent written examination (Part I) was given March 23, 2002; 65 candidates were examined. The most recent oral examination (Part II) was given September 21, 2002; 70 candidates were examined. The pass/fail rates are shown in Table 2 on page 39.

Geographic/gender distribution

As of September 22, 2002, the board has a total of 1,384 diplomates; 1,186 in active practice and 198 retired/inactive, and two with expired certificates. Table 3 on page 39 provides the male/female and international distributions.

American Board of Obstetrics and Gynecology

by Norman F. Gant, MD, Dallas, TX

Oral exam case collection

Commencing with residents graduating in June 2002, the length of time between successful completion of the written examination and the oral examination was shortened by one year. Specifically, after completion of the written examination on the last Monday in June, the candidate may begin collection of cases on July 1. Individuals who have not completed their residency before August 31 will not be allowed to begin case collection until the following July.

Implementation of this new policy will require a transitional phase-in period of three years. For the winter year examinations for 2003-2004, 2004-2005, and 2005-2006 one additional oral examination session will be scheduled for February. Unfortunately, it is unlikely that all candidates wishing to accelerate their certification process can be accommodated. Therefore, up to one-third of residents graduating in the years 2002, 2003, and 2004 will be allowed to enter this accelerated process each year. Of those eligible (that is, those who pass the June written examination), the application process is the same as other candidates, but case collection should begin immediately after completion of the written examination.

A lottery system will be used to select up to 450 eligible applicants from the graduating classes of 2002, 2003, and 2004. *No late applications will be accepted, and all deadlines and requirements must be met in order for candidates to participate in the transitional program.* For those persons not selected in the lottery process, application fees will be refunded and case collection may be continued for the following year's examination. For those persons selected for the process, application fees will not be refunded if the process is canceled or not successfully completed.

Exams

The principal written examination was administered on June 25, 2001, at multiple sites. A total

of 1,711 candidates applied for the exam. Of them, 1,218 were new applicants, 1,138 were U.S. medical school graduates (USMGs), 80 were international medical school graduates (IMGs), and 493 were reapplying. Of those persons reapplying, 343 were USMGs and 150 were IMGs.

Of the individuals who took the written exam, 1,214 (76%) passed, and 389 (24%) failed. Of the USMGs, 1,134 (80%) passed, and 278 (20%) failed. Among the IMGs, 71 (39%) passed and 111 (61%) failed. First-time takers included 1,103 individuals (91%) who passed the test, and 114 (9%) who failed. U.S. graduates accounted for 1,040 (91%) of the individuals who took the exam for the first time and passed; however, 99 (9%) of the first-time USMGs failed. Among those who reapplied for the exam, 111 (29%) passed, and 275 (71%) failed.

The principal oral examination was administered in November and December 2001 and January 2002 in Dallas, TX. A total of 1,469 candidates applied for the oral exam: 16 were disapproved ad hoc; five were disapproved based on case list; 67 turned in incomplete-no fee applications; four were no-shows; 44 withdrew from the exam; and 1,333 took the exam. Of the individuals who took the exam, 1,132 (85%) passed, and 201 (15%) failed. Of the candidates who passed the exam, 1,061 (86%) were USMGs, 71 (76%) were IMGs, and 977 (88%) were USMGs who took the test for the first time. Of the individuals who failed the exam, 179 (14%) were USMGs, 22 (24%) were IMGs, and 132 (12%) were USMGs who took the test for the first time.

The pass rates for the principal written examination in obstetrics and gynecology have remained in a narrow range for more than a decade. For U.S. graduates of American medical schools taking the examination for the first time, the pass rate has ranged between 87 and 95 percent. For the entire examination, the pass rate has ranged between 66 and 76 percent.

The number of applicants for the written examination peaked in the mid-1990s. Since 1997, however, the number of applicants has decreased through the year 2001.

The pass rates for all candidates for the principal oral examination in obstetrics and gynecology have varied from 83 to 87 percent for the past decade. The number of applicants for the principal oral examination was constant between 1996 and 1999 (range: 1,650-1,686). This number dropped abruptly by more than 100 to 1,543 in the year 2000 and to 1,469 in 2001. This finding likely reflects the decreasing total number of applicants for the principal written examination first noted in the years 1997 and 1998.

Subspeciality exams

The written examinations in maternal-fetal medicine (MFM) and reproductive endocrinology/infertility (REI) were administered June 25, 2001, at multiple sites.

Of the 124 individuals taking the MFM written exam, 108 (87%) passed and 16 (13%) failed. Of those persons who passed the exam, 83 (98%) were first-time takers and 25 (64%) were reapplicants.

Of the 68 persons taking the REI written exam, 58 (85%) passed and 10 (15%) failed. Of those persons who passed the exam, 42 (89%) were first-time takers and 16 (76%) were reapplicants.

Subspecialty oral examinations were administered April 17-19, 2001. In the subspecialty of REI, 64 individuals took the oral exam, and 47 (73%) of them passed. A total of 852 physicians are board-certified in REI to date. In the subspecialty of MFM, 76 individuals took the oral exam, and 65 (86%) of them passed. A total of 1,419 are board-certified in REI to date. In the subspecialty of gynecologic oncology (GO), 33 individuals took the oral exam and 28 (85%) passed. A total of 690 physicians are board-certified in GO to date.

Trends/written exams: The number of applications, those individuals approved to take the examinations, and the actual number who took the subspecialty written examinations in MFM and REI have declined for the past two years. This finding likely reflects the marked decrease in applicants for these fellowship positions first noted three years ago. The pass rates for the written examinations in MFM and REI have remained stable since the mid-1990s: between 75 and 90 percent.

Trends/oral exams: The pass-fail percentage rates for the oral subspecialty examinations are listed by year from 1990 to 2001 (see table, page 42).

A total of 2,961 diplomates have been issued subspecialty certificates (GO, MFM, REI), of whom approximately 2,690 are currently in practice.

This number represents approximately 7.8 percent of the total of 34,158 actively practicing diplomates.

Maintenance of certification

Certificate renewal/voluntary recertification written exams were administered February 26, 2001, at multiple sites. Of those physicians seeking to renew their certificates in obstetrics/gynecology (ob-gyn), 146 (98%) passed, and three (2%) failed. Of those physicians voluntarily renewing their certificates in ob-gyn, five (100%) passed. Of those individuals certified in ob-gyn and GO who were up for certificate renewal, two (100%) passed. A total of 15 persons certified in MFM and ob-gyn sought to renew their certificates and one voluntarily sought recertification. All passed. A total of 10 individuals sought to renew their certificates in ob-gyn and REI; nine passed and one failed.

A maintenance of certification exam in ob-gyn was administered August 27, 2001, in Dallas, TX. Of 46 physicians seeking to renew their certificates, 45 (98%) passed, one failed. Two physicians voluntarily sought recertification, and both passed.

A total of 5,485 individuals applied for annual board certificate (ABC) renewal and voluntary recertification for 2001. Of the ob-gyn applications, 4,789 were approved, 11 were disapproved, eight were withdrawn, and 252 were incomplete. There were 383 MFM applications, of which 380 were approved, one was disapproved, two withdrew, and 20 were incomplete. There were 171 REI applications, of which 169 were approved, one was disapproved, one was withdrawn, and 14 were incomplete.

For the obstetrics and gynecology portion of the ABC process several points are obvious.

Approval of applications in the years 1998, 1999, 2000, and 2001 was 97.5 percent, 99.8 percent, 99.7 percent, and 99.6 percent, respectively. The number of applications in 1999 (3,292) was decreased from 1998 (4,098). This decrease of 20 percent likely is explained by individuals who did not complete the process in 1998 and did not apply in 1999, plus the attrition of those persons who simply did not wish to continue the process for a variety of reasons. The increase back to 4,092 in 2000 and 4,808 in 2001 almost certainly represents the influx of another group of diplomates with time-limited certificates choosing this method of certification maintenance.

Oral subspecialty examinations: Pass-fail percentage rates 1990-2001

	GO		MFM		REI	
	Pass	Fail	Pass	Fail	Pass	Fail
1990	71%	29%	78%	22%	65%	35%
1991	61	39	79	21	63	37
1992	78	22	83	17	55	45
1994	85	15	80	20	69	31
1995	77	23	81	19	75	25
1996	85	15	79	21	73	27
1997	79	21	82	18	64	36
1998	86	14	81	19	64	36
1999	89	11	78	22	76	24
2000	80	20	89	11	69	31
2001	85	15	86	14	73	27

The percentage of diplomates who did not complete the process decreased from 30 percent in 1998 to 11 percent in 1999. In 2000, this number had decreased to 8 percent, and in 2001 this number was 5 percent. As mentioned previously, this improvement likely represents the loss of those who failed to complete the process in 1998. Also, this number likely includes a new group of diplomates with time-limited certificates and a better understanding of the process. More than 70 percent of diplomates using the ABC process in 1998 and 1999 did so voluntarily. This percentage fell in 2000 to 57 percent and in 2001 this number was 50 percent, as expected, due to the entry of more diplomates with time-limited certificates.

Analysis of the subspecialties after three years reveals several similarities to the ABC process in obstetrics and gynecology. Approvals of applications have been 100 percent and 98.5 percent in 1999 and 2000 respectively, and 99 percent in 2001. Since 1999, those failing and/or not completing the subspecialty ABC process appear to be decreasing. The reasons for this decrease are simi-

lar to those associated with the maintenance of certification examination in obstetrics and gynecology. Specifically, the attrition in 1999 likely resulted from those diplomates who did not understand the process or who discovered they did not wish to continue this form of recertification. The numbers of subspecialists actually entering the ABC subspecialty examination process in 1999 (686), 2000 (510), and 2001 (671) certainly support this conclusion. The subspecialists, using the ABC process in obstetrics and gynecology, are doing so slightly more often voluntarily. The 1999 voluntary rate was 77 percent, the 2000 voluntary rate decreased moderately to 61 percent, and in 2001 this rate was 55 percent.

Officers and directors

The ABOG officers for the year ending June 30, 2002, were: Gerson Weiss, MD, president; Michael T. Mennuti, MD, vice-president; Ronald S. Gibbs, MD, treasurer; Robert C. Cefalo, MD, PhD, chairman of the board; Norman F. Gant, MD, executive director; and William Droegemueller, MD, director of evaluation. Directors included Haywood L. Brown, MD; Larry J. Copeland, MD, FACS; Alan H. DeCherney, MD, FACS; Philip J. DiSaia, MD, FACS; Sherman Elias, MD, FACS; Wesley C. Fowler, Jr., MD, FACS; Larry C. Gilstrap III, MD; Frank W. Ling, MD; Roy T. Nakayama, MD; Kenneth L. Noller, MD; Valerie M. Parisi, MD; Nanette F. Santoro, MD; and Morton A. Stenchever, MD.

In addition, the following individuals served as the directors and representatives of the subspecialty divisions: Dr. Copeland, division of GO; Dr. Parisi, division of MFM; and Dr. Santoro, division of REI. Dr. Stenchever is the director and representative for female pelvic medicine and reconstructive surgery.

American Board of Ophthalmology

by Lee R. Duffner, MD, FACS, Golden Beach, FL

Certification examinations

The fall oral examination and meeting of the American Board of Ophthalmology (ABO) was held October 26-28, 2001, in Cambridge, MA. The annual meeting was held Friday, November 8, 2002, in San Francisco, CA.

The future dates for examinations are as follows: Written qualifying examination—April 11, 2003, and April 16, 2004. Oral examination—2003, June 6-8 in Philadelphia, PA, and October 24-26 in Cambridge, MA; 2004, May 14-16 in San Francisco, CA, and November 12-14 in San Francisco, CA.

The total number of diplomates certified at the October 2001 Cambridge and June 2002 San Francisco oral examinations was 456 (217 in Cambridge; 239 in San Francisco). Eighty-five failed the examination and must repeat all six subjects.

The 2002 written qualifying examination was held April 26, 2002, at three sites in the U.S. The questions in this examination were prepared by the written examination committee of the ABO and the ophthalmic knowledge assessment program committee of the American Academy of Ophthalmology. It is the responsibility of the written examination committee to review and approve the final questions.

Of the 730 registered for the 2002 written qualifying examination (WQE), 658 took the examination, 227 failed (34.5%), and 431 passed. Of the 227 who failed, 133 (58.59%) failed previously. Of the 658 candidates who took the examination, 206 (31.30%) were repeaters, and of these 133 (64.56%) failed again.

International medical graduates constituted 12.31 percent (81 candidates) of the examination and 44 failed (54.32%). U.S./Canadian graduates constituted 87.69 percent (577 candidates) and 183 (31.72%) failed.

Of the 206 candidates repeating the WQE, 40

(19.42%) were international medical graduates and 166 (80.58%) were U.S./Canadian graduates.

The candidates who passed the 2002 WQE plus the repeaters from previous oral examinations provide a potential pool of 261 candidates for the November 2002 San Francisco oral examination and 263 potential candidates for the June 2003 Philadelphia oral examination.

Recertification examinations

The future dates for examinations are as follows: Certificate renewal examination, written (CREW), February 1 through March 31, 2003 (this is a take-home examination with two months to complete); Office record review (ORR), January 1-31, 2003, and July 1-31, 2003 (given twice a year with one month to complete).

The 2002 CREW examination was administered as a take-home examination from February 1 through March 31, 2002. Of the 351 registered for this examination, 346 completed the examination with 334 passing (96.53%) and 12 failing (3.47%).

The ORR was administered July 1 through July 31, 2001, and January 1 through January 31, 2002. Of the 42 registered for the July 2001 examination, 39 passed the review and three were incomplete. At the January 2002 examination, 243 were registered, with 241 passing and two incomplete.

Representation

The representative to the American College of Surgeons for 2002 was Lee R. Duffner, MD, FACS. The board's representatives to the residency review committee for the year 2002 were: Susan H. Day, MD, Richard P. Mills, MD, FACS, and James S. Tiedeman, MD.

In 2002, the residency review committee for ophthalmology reviewed 52 of 122 accredited ophthalmology residencies, with 23 receiving full reviews and the remainder partial reviews (either progress reports or requests for change in numbers of residents); of the fully reviewed programs, 20 were granted continued full accreditation, one proposed probation, one confirmed probation, and one deferred until the June 2002 meeting.

The following directors became officers of the board for 2002: chairman, Dr. Duffner, vice-chairman, and M. Bruce Shields, MD, FACS.

The two new board directors who took office January 1, 2002, were Martha J. Farber, MD, and David Tse, MD, FACS.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2002 were: Edward G. Buckley, MD, FACS; Dr. Mills; Dr. Shields; and Charles P. Wilkinson, MD. Denis M. O'Day, MD, FACS, is on the executive committee of the ABMS.

General information

The American Board of Ophthalmology continues transitioning the recertification process into a program of maintenance of certification (MOC). MOC will be a continuous process that is part of a physician's professional life and will be based on the following four components: evidence of professional standing; evidence of commitment to lifelong learning and involvement in self-assessment; evidence of cognitive expertise; and evidence of evaluation of performance in practice.

In addition to the four components, MOC will contain six domains of competence. These are patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Ophthalmology has added a seventh competency in surgery.

Each of the six domains of competence has guidelines developed by ABMS committees. This is an outgrowth of the committee formed a couple of years ago to evaluate medical school performance in the competencies. Not only will these competencies be used at the MOC level, but they will also be part of the final resident evaluations sent to the ABO. At the completion of an individual's residency, the board will require a satisfactory performance rating in these seven competencies before he or she may sit for boards. To assist the process at the residency level, the ABO has taken the initiative of working with ophthalmology program directors to form a task force on competency.

The certificates for the first group of time-limited certificate holders expired December 31, 2002. These individuals received their certificates in 1992 and they are time-limited for 10 years.

American Board of Surgery

by Frank R. Lewis, Jr., MD, FACS, Philadelphia, PA

The following report summarizes the events of the 2001-2002 academic year, which has been a full one for the American Board of Surgery (ABS). A number of these issues should be of interest to the Fellows of the College.

New initiatives in education

The board held a retreat in January 2002 on the subject, "Graduate Surgical Education: Present Trends, Future Initiatives." The purposes of the retreat were: (1) to examine the changing demographics of applicants for residency positions in surgery and its specialties; and (2) to examine the concepts of contracted training and tracking in an effort to make the process more efficient, effective, and less time-consuming. In addition to the ABS directors (who provided representation from the American Board of Thoracic Surgery, American Board of Plastic Surgery, and American Board of Colon Rectal Surgery), broad representation was present from the American College of Surgeons, the residency review committee for surgery (RRC-S), and the Association of Program Directors in Surgery. All members of the Boards of Vascular Surgery and Pediatric Surgery of the ABS and the Surgical Oncology Advisory Council (SOAC) were also included.

There was general agreement that numerous indicators pointed to a downward trend in the size (and possibly the quality) of the applicant pool for surgery for approximately the last five to seven years. These issues have become more visible with the failure of categorical surgical residency positions to fill completely during the last four years. For the last two years, 68 and 58 positions, respectively, of categorical positions did not fill. Mirroring the trend in general surgery, residencies in thoracic surgery and vascular surgery have also noted a declining pool of applicants, such that the number of applicants to available positions is approaching one to one. This issue, in part, led the American Board of Thoracic Surgery in October 2001 to abandon the requirement for holding an ABS certificate before entering thoracic surgery residency, and instead opening the possibility of entering thoracic residency after only three years of general surgical training.

Factors identified as causative in this declining interest were the following:

- *Lifestyle issues*. The perception exists of adverse working conditions in surgical residency, with work weeks in excess of 100 hours, excessive service requirements without educational value, and disaffected surgical faculty. Generation Xers have different values from earlier generations, and want more balance between professional and personal life as well as greater control of their personal time; they are not willing to spend time in the hospital while neglecting personal interests and family.
- *Gender issues*. Women constitute roughly 50 percent of medical school classes, but only 15 percent of surgical residents. Residencies must consider issues specifically addressed to women, such as child care provisions and more realistic maternity policies.
- *Image of surgery issues*. Surgery is often perceived as not being on the cutting edge of new knowledge, and of becoming progressively less relevant in the face of new technology (for example, endovascular, robotics). In addition, many of the practical issues of practice—decreased reimbursement, decreased autonomy, and increased administrative hassles—have made a surgical career less attractive. In most medical schools, time spent on surgical rotations has been significantly reduced in the last two decades, and medical students often have little or no exposure to the best and brightest of surgical faculty.
- *Personal indebtedness*. The degree of indebtedness has risen dramatically in the last 10 years, and is now a factor in specialty selection because of the effect on personal lifestyle and family security.

The issues and problems were discussed extensively. Ultimately, the directors adopted the con-

cept of initiating a pilot program for the specialties that are essential content areas (also known as primary components) of general surgery; if successful, such a program would allow shortening of total training by one year. It was considered essential that the validity of the basic ABS certificate be maintained. The core of the proposal would allow residents to enter specialty training after four years of general surgery, spend the fifth year in the specialty, and then one or two additional years to complete specialty training. The fifth year would count as the fifth year of general surgery as well as the first year of specialty training.

Following the retreat, a request was directed to the American Board of Medical Specialties for approval of the above concept, in which the fifth year could count toward two different ABS certificates. That approval was granted, and a committee was appointed—the ad hoc committee for the early specialization program (ESP).

Further discussion ensued at the June ABS meeting and additional directives were provided to the committee to clarify the charge. The committee met August 5, 2002, and developed a draft report which is currently being circulated to all ABS directors and RRC-S members. There was a relative unanimity in favor of the ESP, and a recommendation that it be extended to vascular and pediatrics, but not critical care or hand. Specialties that have independent boards—thoracic surgery, plastic surgery, and colon and rectal surgery—may also be interested in this paradigm, but the approval process for any combined program will be different, and will have to go through the ABMS as a formally combined residency program. Initiatives in that area will be explored in the future.

The report will be reviewed extensively and revised as necessary. It was to be presented to the ABS directors in January for adoption, and if successful, the ESP program would be implemented shortly thereafter. The committee report has emphasized that the success of these programs must be judged by the ability of ESP graduates and other residents in programs where ESP is initiated to maintain the same pass rates on the qualifying exam and certifying exam as their peers. It is also considered essential that all minimums currently mandated by the RRC-S be maintained for future graduates of these programs. These will initially have to be evaluated on a year-to-year basis.

IT/SBSE suspicious matches

Three years ago, the ABS purchased software designed to detect cheating on multiple-choice examinations, and initially used this to examine the results in the In-Training/Surgical Basic Science Examinations (IT/SBSE) from 1997 to 1999. The software makes it possible to detect suspicious "matches" in the selection of the same answers on two or more examinee's answer sheets and to compare these. In general, when there are matches in the correct answers, one cannot detect cheating, since the argument is easily made that those examinees with a high percentage of identical right answers were simply well-informed and there is only one right answer for each question. Hence, the software compares matches of wrong answers. Since there are four possibilities of being wrong per question, a substantial match of wrong answers throughout an exam argues highly that the answers were copied from one to the other.

The software can be set at various levels of significance, and obviously detects more suspicious matches the lower the significance level is set. We have chosen to use it very conservatively, and have only identified suspicious episodes when the statistical probability of a "chance" occurrence is less than one in a million. ($p < 0.0000001$)

When this software was first applied to the 1997-1999 IT/SBSEs, 65-70 programs per year were found to have episodes of suspicious matches identified. Most of these were single pairs of examinees, but a few were notable for having "trios," in which three-way matches were identified. After the 1999 IT/SBSE, program directors were notified of the findings and asked to proctor their subsequent examinations more closely. A year later, in 2000, they were notified that if the ABS detected cheating for three years sequentially in a program they would withhold the IT/SBSE from that program subsequently.

In 2000, the number of programs identified fell to 45, and in 2001 to 27. In 2002 the number rose again to 38 programs. This is the second year of results under the new policy, so no program has yet faced recision.

This software has also been used to compare the incidence of suspicious matches on the qualifying examination and the recertification examination, both given to 1,100-1,500 individuals yearly, which are proctored closely by board directors to avoid the possibility of copying. There have been rare instances of matches identified, never more than two pairs per year in either of these exams.

For the past two years, both the qualifying and recertification examinations were printed in two versions with the same questions, but placed in a different sequence in the two books. Proctors were instructed to alternate versions of the booklet with alternate examinees. With this modification, no matches of answer sheets occurred in either examination.

At its meeting on June 24-25, 2002, the ABS discussed this phenomena, and felt that stronger action needs to be taken to reduce the number of these occurrences on the IT/SBSE. The following plan was adopted:

1. At the first identification of any suspicious matches in a program, the program director and chair of surgery will be notified of the occurrence and asked to make some specific changes in the conduct of the examination (assigned seating, closer proctoring, escorts for those leaving room).
2. If the same program has a suspicious occurrence in the next year, the program director, chair of surgery, and medical education director for the institution will be notified. The medical education committee for the institution will be asked to submit a written plan to correct the problem.
3. If the same institution has a suspicious match for a third year, the previously mentioned individuals will again be notified, and the IT/SBSE will be withheld for at least one year. The procedure for regaining entrance to the examination has not yet been determined but will be developed in the next six months. The RRC-S will also be notified that the program will not be allowed to receive the IT/SBSE.

The ABS is also debating whether it would be useful to print two or more versions of the examination booklet for the IT/SBSE, as this has not been done to date. Subsequent to the ABS action described, the issue was presented to the RRC-S, and they strongly supported the actions that had been taken.

Competence initiative

The ABS has previously adopted the maintenance of certification (MOC) initiative of the ABMS, and has implemented some of its requirements. The program has four basic components: (1) evidence of professional standing; (2) evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process; (3) evidence of cognitive expertise; and (4) evidence of evaluation of performance in practice.

The first of these components is evaluated by the requirement for a full and unrestricted license in all jurisdictions where licenses are held by a diplomate, and by personal reference requirements from the chief of surgery and the chair of the credentials committee in the hospitals where the diplomate practices.

The second requirement is met by demonstration of 100 hours of CME activities in the two years prior to recertification application, of which 60 hours must be Category I. The third requirement is met by taking and passing the recertification examination of the ABS. The fourth requirement is met in part currently by the reference letters of the chief of surgery and the chair of the credentials committee, but it is felt that more objective criteria are needed, which specifically would address the practice experience of an individual diplomate.

Currently, initiatives have been undertaken by the Vascular Surgery Board of the ABS (VSB-ABS), the Pediatric Surgery Board of the ABS (PSB-ABS), and the SOAC, which are geared to obtaining outcomes measures that could be used in the MOC process.

The VSB-ABS has initiated a program to measure specific outcomes of three index procedures: carotid endarterectomy, elective repair of infrarenal aortic aneurysms, and infrainguinal bypass. Under the leadership of Pat Clagett, MD, FACS, the VSB-ABS has moved ahead with planning for implementation of this program in the last year, and it is anticipated that it will be initiated during the recertification process for vascular surgeons seeking recertification in 2003.

The PSB-ABS, under the leadership of Brad Rodgers, MD, FACS, had adopted a similar approach and has identified seven conditions that will be utilized as index conditions for evaluat-

ing outcomes. They have been working with the clinical trials center of the American Pediatric Surgical Association in developing a short form in which a practitioner could compare his or her own results with regional or national norms in a confidential way.

Finally, the SOAC, chaired by Timothy Eberlein, MD, FACS, has explored the possibility of using the National Surgical Quality Improvement Program (NSQIP), developed by Shukri Khuri, MD, FACS, in the Veterans Affairs Hospital System. Dr. Eberlein and the members of the council have explored using data collected as part of the NSQIP process where it applies to the outcomes of surgical oncology procedures, and using these as the index of practice performance.

These three initiatives are all moving forward, and will be evaluated for effectiveness and acceptability to diplomates. Ultimately, a method will have to be found that is applicable to general surgery diplomates, but the ABS felt that the smaller number of practitioners in the above areas and the more homogeneous nature of the practices would allow us to more quickly identify effective and workable methods to meet MOC requirements.

Independent vascular surgery board

The American Board of Vascular Surgery has moved ahead with an application to the ABMS for creation of an independent board, which was filed in early June 2002. (The full application can be viewed online at *www.vascularweb.org*.) The application will be reviewed first by the Liaison Committee for Specialty Boards (LCSB), which is appointed jointly by the ABMS and the AMA. Initial review was scheduled for December 2002.

The membership of the LCSB consists of:

ABMS: David L. Nahrwold, MD, FACS; Harvey Meislin, MD; Joel A. DeLisa, MD; and John S. Strauss, MD.

AMA: Richard Allen, MD; James L. Borland, Jr., MD; Emmanuel G. Cassimatis, MD; Rebecca J. Patchin, MD; and Barbara Burzanski, PhD.

The ABVS application makes a good case for a vascular certificate, but such a certificate has existed under the aegis of the ABS for more than 20 years. The ABS strongly opposes the initiative for an independent board. It appears from reading the application that an intent of the independent board is to limit the vascular surgical experience of general surgery residents and direct these cases instead to vascular surgical trainees. Since experience in vascular surgery is essential to several content areas of general surgery, it is impossible for ABS to abandon this area as an essential content area.

If the action of the LCSB is to deny the application, it will move no further at this time. If it is approved, it will move to the ABMS executive committee, and if approved there, to the ABMS assembly.

Naming of new executive director

A search committee consisting of Patricia Numann, MD, FACS (chair); Mark Malangoni, MD, FACS; and J. David Richardson, MD, FACS, initiated the search process for a new executive director after Wallace P. Ritchie, Jr., MD, FACS, indicated in April 2001 his intent to retire in June 2002. The search committee interviewed all directors, several senior directors, and ABS office staff to determine views on the current status of the ABS, its future directions, and the characteristics needed in a future executive director. An RFP was widely disseminated in the summer of 2001, and widespread interest in the position was expressed. Ten candidates were interviewed, and final recommendations were submitted to the board at its January 2002 meeting. Frank R. Lewis, Jr., MD, FACS, was selected by the board after the search committee presented its recommendations and he shortly thereafter accepted the position. Overlap of approximately six weeks with Dr. Ritchie was scheduled, and on July 1, 2002, Dr. Ritchie officially retired and Dr. Lewis assumed the executive director responsibilities.

New and retiring members

The board would like to express its thanks for the dedicated service and excellent counsel of the following individuals who retired in 2002: (ABS directors) Robert W. Barnes, MD, FACS; Robert D. Fry, MD, FACS; Donald L. Kaminski, MD, FACS; Dr. Numann (chair, 2001-2002); (VSB-ABS) Keith D. Calligaro, MD, FACS; and (SOAC) Daniel G. Coit, MD, FACS.

American Board of Surgery:
Summary of 2001-2002 examinations

Examination	Number of examinees	Pass rate	Diplomates to date
Qualifying	1,287	79%	
Certifying	1,168	83	47,367
Recertification	1,370	93	12,991
Vascular surgery qualifying	123	80	
Vascular surgery certifying	120	83	2,154
Vascular surgery recertification	138	94	1,137
Surgical critical care certification	83	95	1,939
Surgical critical care recertification	163	91	687
Pediatric surgery qualifying	68	96	N/A
Pediatric surgery certifying	69	87	877
Pediatric surgery recertification	67	94	498
Hand surgery certification	5	100	223
Hand surgery recertification	12	92	63
Pediatric surgery ITE	72	N/A	N/A
IT/SBSE	7,336	N/A	N/A
Total	12,081*		

N/A - Not applicable.
*4,745 examinees, excluding the IT/SBSE and pediatric surgery ITE.

New appointees elected in April to replace the above individuals, and the appointing organizations, are the following:

(*ABS directors):* Richard H. Bell, Jr., MD, FACS, American Surgical Association; James W. Fleshman, Jr., MD, FACS, American Board of Colon and Rectal Surgery; Russell G. Postier, MD, FACS, American Medical Association; and Steven C. Stain, MD, FACS, Western Surgical Association.

(VSB-ABS): Bruce L. Gewertz, MD, Society for Vascular Surgery.

(SOAC): Fabrizio Michelassi, MD, FACS, Society of Surgical Oncology.

We want to welcome all of them enthusiastically, and look forward to working with them.

The board would also like to gratefully acknowledge the dedicated service of the following individuals who retired from active examiner status during the past year: Robert W. Barnes, MD, FACS; Edward M. Copeland III, MD, FACS; Haile T. Debas, MD, FACS; Josef E. Fischer, MD, FACS; Peter C. Pairolero, MD, FACS; and Donald D. Trunkey, MD, FACS.

Necrology

It is with great regret that we report the deaths of the following individuals during the past year: Jonathan E. Rhoads, MD, FACS (January 3, 2002); Jack Cole, MD, FACS (June 2002); Victor Richards, MD, FACS (July 13, 2002); David Tapper, MD, FACS (July 23, 2002), and C. James Carrico, MD, FACS (July 25, 2002).

American Board of Urology

by Martin I. Resnick, MD, FACS, Cleveland, OH

Exams

The certification process of the American Board of Urology (ABU) incorporates a qualifying examination (Part I) and a subsequent certifying examination (Part II). Admissibility to the qualifying examination requires that the applicants have completed or be within six months of satisfactorily completing an Accreditation Council on Graduate Medical Education (ACGME)-approved urology residency program. Admissibility to the certifying examination requires that the candidates have passed the qualifying (Part 1) examination, have 18 months of clinical practice experience in a single community, submit an acceptable practice log, and receive satisfactory peer reviews.

On June 27 and 28, 2002, 351 candidates completed the qualifying (Part I) examination, which consists of three components: An imaging examination, a pathology examination, and the qualifying (Part 1) examination. All three examinations are given in booklet form and are cognitive, multiple-choice examinations. Of the three component examinations: 286 sat for the imaging examination, 282 passed and four failed; 283 sat for the pathology examination, 276 passed and seven failed; and 329 sat for the written qualifying (Part 1) examination, 270 passed and 59 failed.

As has been true in other years, practitioners—U.S.- or foreign-educated—who have previously failed the examination had a high failure rate on re-examination. For the past 10 years, the pass level for the qualifying examination has been set by the criterion reference method, equated to a previous benchmark test, using the Rasch model. The passing score will vary according to the difficulty of the examination for any year. Thus, although examination may vary in difficulty from year to year, the probability of passing (pass rate) is based solely on the ability of the candidate pool in any given year. This is a fair and defensible methodology, which does not impose an arbitrary pass/fail point.

The 2002 certifying (Part 2) examination is a standardized oral examination that consists of six protocols on which the candidate is tested. In February 2002, 277 candidates took the certifying (Part 2) examination; 262 (95%) passed and were certified; 15 (5%) failed, a pass rate much higher than that of recent years. The board uses a modified Rasch model for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. Consistent with the board's commitment to continually improving its evaluation processes, in 1995 the board applied a dual scoring system for the oral examination protocols. Separate grades are utilized for information gathering and diagnosis, and for problem-solving and patient management. This system has resulted in a significant increase in statistical reliability. The board is pleased with this scoring technique for the oral examination.

Certification

The board requires completion of certification within five years of completion of an ACGME-approved residency program; extensions are granted for approved fellowship training. Failure to complete certification within the time allotted requires reentry into the certification process at the qualifying examination (Part I) level after first passing a preliminary examination.

In 1992, the board began its mandatory recertification process for all diplomates with 10-year time-limited certificates, which have been issued since 1985. Currently, all trustees of the ABU recertify during their tenure on the board. The process consists of multiple components. These various components provide the diplomate with different opportunities and ways to document his or her competence. A modular, written, open-book examination consists of five subject areas from which the diplomate will choose three with which he or she is most comfortable. Each module has 20 questions, for an individual examination of 60 questions. Other components include peer review, a surgical log review, and a CME requirement. In addition, at the board's

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Women's Hospital, Boston, MA. Research to be performed at Stanford University. Research project: Microarray Analysis of Fetal Wounds. The scholarship is sponsored by Ethicon, Inc.

Elizabeth Jay Renaud, MD, resident in surgery, Boston University, Boston, MA. Research to be performed at Massachusetts General Hospital. Research project: The Role of Mullerian Inhibiting Substance and the Mullerian Inhibiting Substance Type II Receptor in Neoplasms of Mullerian Duct Origin. The scholarship is sponsored by the Scholarship Endowment Fund of the College.

Further information regarding the scholarships, fellowships, and awards offered by the College for 2004 was published in the January *Bulletin* and appears on the College's Web site, *www.facs.org/dept/fellowship/acsresident.html*.

Trauma meetings calendar

The following continuing medical education courses in trauma are scheduled.

The courses are sponsored by the American College of Surgeons Committee on Trauma and Regional Committees.

- **Trauma and Critical Care 2003—Point/Counterpoint XXII,** June 2-4, 2003, Atlantic City, NJ.
- **Advances in Trauma,** December 12-13, 2003, Kansas City, MO.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at *http://www.facs.org/dept/trauma/cme/traumtgs.html* or by contacting the Trauma Office at 312/202-5342.

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discretion, hospital/office chart reviews, an oral interview or examination, and/or a site visit may be required. Diplomates may enter the recertification process up to three years before expiration of the primary certificate. Upon successful recertification, the diplomate is issued a certificate valid for 10 years from the date of expiration of the original certificate. In November 2001, 212 diplomates sat for recertification; 210 diplomates (99%) successfully completed the recertification process.

Currently, there is discussion among the ABMS member boards regarding maintenance of certification that would entail, among other things, ongoing monitoring of physicians by the certifying boards. The ABU is actively discussing the maintenance of certification issue, but the trustees have significant concerns regarding the implementation of the proposal.

Officers and trustees

Current officers and trustees are: Martin I. Resnick, MD, FACS, president; Michael E. Mitchell, MD, FACS, vice-president; Paul F. Schellhammer, MD, FACS, president-elect; Joseph A. Smith, Jr., MD, FACS, secretary-treasurer; Peter C. Albertsen, MD, FACS; Peter R. Carroll, MD, FACS; Michael J. Droller, MD; Robert C. Flanigan, MD, FACS; Mani Menon, MD, FACS; Linda M. Shortliffe, MD, FACS; Howard M. Snyder III, MD, FACS; and Robert M. Weiss, MD, FACS. Ω