

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 and other interested readers 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* will feature the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, the American Board of Orthopaedic Surgery, the American Board of Surgery, and the American Board of Thoracic Surgery.

The March issue of the *Bulletin* contained reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Plastic Surgery, and the American Board of Urology.

The American Board of Colon and Rectal Surgery

by Herand Abcarian, MD, FACS, Chicago, IL

The American Board of Colon and Rectal Surgery (ABCRS) held its most recent annual meeting September 21, 2003, and its most recent interim meeting March 23, 2003, in Chicago, IL. Future meetings will be held at the Omni Hotel in Chicago through 2006. The schedule is as follows:

Written examination/interim meeting: March 20-21, 2004, March 19-20, 2005, and March 25-26, 2006.

Oral examination/annual meeting: October 1-3, 2004, September 23-25, 2005, and September 29-October 1, 2006.

Officers/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 American Board of Colon and Rectal Surgery (ABCRS) nominates four members; the American Society of Colon & Rectal Surgeons (ASCRS) nominates four; the American College of Surgeons (ACS) nominates two; the American Medical Association (AMA) nominates one; the Association of Program Directors for Colon and Rectal Surgery (APDCRS) nominates two; and the American Board of Surgery (ABS) nominates one. Board members normally serve two four-year terms—a total of eight years.

The board's current officers are: James W. Fleshman, MD, FACS, president; Alan G. Thorson, 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; Marshall M. Urist, MD, FACS; Bruce G. Wolff, MD, FACS; and W. Douglas Wong, MD, FACS.

Examination committee activities

The board's examination committee is chaired by Dr. Fleshman. It is divided into three working

groups consisting of the oral, written, and recertification subcommittees; each is directed by a separate chairman. A summary of the subcommittee activities follows.

Oral examination. The ABCRS oral examination committee, under the direction of Dr. Hicks, continues to focus its attention on standardizing the oral examination process. Early in 2002 the committee began this task by editing existing oral case scenarios, making all the options clear, focused, and consistent. Thirty-eight cases were preselected for the September 2002 oral exam, and all examiners were instructed to test on the same material and gather responses in key elements from each candidate. In January 2003, committee members met to review the 2002 oral examination. The most and least missed questions were evaluated. Some were deleted, but most were kept and modified. Committee members were assigned specific topics and wrote new cases for the 2003 oral examination and for the oral case pool. New cases were preselected, and the 2003 oral examination was constructed.

The committee's goal is to change the oral examination from one that merely tests candidates' recall ability to one that tests their cognitive knowledge. It is predicted that these changes will make the oral process more objective and provide a mechanism that will better identify the areas in which candidates fail.

Written examination. At the March 23, 2003, board meeting, Dr. Wolff, chairman of the written examination committee, made a proposal to combine the radiology and pathology sections of the written examination into one visual diagnostic examination. The current radiology pool will be reviewed and categorized. Poor-quality cases will be deleted and new high-quality cases will be added. Additions will include not only endoscopic examples, but also examples of gross pathology, such as prolapsed hemorrhoids, rectal prolapse, and fissures. Cases with corresponding photos that incorporate findings on visual and physical examination, as well as various diagnostic tests, includ-

ing manometry, MRI, CT, and histology on biopsy will be used. Eventually, the pathology and radiology examinations will be combined into one digitalized diagnostic exam.

Dr. Wolff said he believes these changes will make the examination more specialty-relevant. The images and corresponding cases will more closely resemble “real life” scenarios and authentic practice settings germane to colon and rectal surgery. Also, the examination will be projected using contemporary digital equipment, which will facilitate the interpretation of material. Ultimately, the changes will make the examination more current, uniform, and streamlined.

Recertification examination. The last recertification examination was given June 21, 2003, in New Orleans, LA. Forty-eight diplomates participated; 46 passed and two failed. The results and statistical summaries for the last 13 years are provided in Table 1 on page 43.

Transition to MOC

At the board’s March 23, 2003, interim meeting, the recertification committee was officially renamed the maintenance of certification (MOC) committee, and is chaired by Dr. Hooks (previously the recertification committee chairman). Under his direction, the ABCRS is making a transition from recertification to the new MOC program as requested by the American Board of Medical Specialties (ABMS).

In March 2003, the ABMS tentatively approved the ABCRS application for the first three components of MOC, including: (1) professional standing; (2) lifelong learning and self-assessment; and (3) cognitive expertise. The board’s next project will be to address the part four requirement—assessment of practice performance. This component will be the most difficult to develop because it requires that boards establish a process for assessing physician practice performance.

Beginning January 1, 2004, the Colon and Rectal Surgery Educational Program (CARSEP) requirements became effective for all diplomates who hold time-limited certificates. The board’s MOC plan requires a 10-year interval between initial certification and completion of requirements to maintain certification for the first time and for each subsequent 10-year interval. Specific requirements to prove professional standing, lifelong

learning, and self-assessment include:

- Completion of CARSEP at least twice during the 10-year MOC interval.
- Approximately 30 Category 1 CME credits will be granted for each program.
- Accumulation of 100 Category 1 CME credit hours will be required two years before MOC application.
- Documentation of active state medical license without restrictions.
- Documentation of local institutional privileges as a “physician/colon and rectal surgeon” in “good standing.”

To fulfill requirements for cognitive expertise, a diplomate must pass a secure written examination covering all areas of colon and rectal surgery. The ABCRS administers a secure written examination every 10 years for all its diplomates certified since 1990 as the “recertification” process. Diplomates now holding unlimited certificates will have access to the board’s MOC programs and are encouraged to participate; however, participation is not necessary to retain the original certification.

Examination results

The most recent written examination (Part I) was given March 22, 2003; 67 candidates were examined. The most recent oral examination (Part II) was given September 20, 2003; 71 candidates were examined. The pass/fail rates are shown in Table 2 on page 43.

Examination fees increased

At its March 23, 2003, meeting, the ABCRS voted to raise its examination fees. Notably, the board has been able to keep examination fees at the same level for more than 15 years; however, escalating examination expenses necessitated the increase. The new fee schedule, effective as of March 2003, is:

Application fee: A nonrefundable fee of \$400 (previously \$300) must accompany the application.

Written examination fee (Part I): A fee of \$500 (previously \$400) is due and payable when the candidate is notified of approval to take the written examination.

Oral examination fee (Part II): A fee of \$700 (previously \$500) is due and payable when the candidate is notified of approval to take the oral examination.

Table 1: ABCRS recertification performance - 1991-2003

Year	Participants	Passed	Percent	Failed	Percent	Maximum	Minimum	Average
2003	48	46	96%	2	4%	92%	66%	82%
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
1997	19	19	100	0	0	97	72	87
1996	5	5	100	0	0	94	85	90
1995	3	3	100	0	0	88	86	87
1994	11	11	100	0	0	98	79	90
1993	7	7	100	0	0	97	85	90
1992	8	8	100	0	0	96	78	90
<u>1991</u>	<u>7</u>	<u>7</u>	<u>100</u>	<u>0</u>	<u>0</u>	<u>97</u>	<u>91</u>	<u>94</u>
Total	257	244	95%	15	5%	98%	57%	86%

Passing score: 70 percent

Table 2: Examination results: Pass/fail rates

	Written exam - March 22, 2003 (67 candidates)					Oral exam - September 20, 2003 (71 candidates)				
	#	Fail rates	%	Pass rates	%	#	Fail rates	%	Pass rates	%
Total candidates	67	11/67	16%	56/67	84%	71	10/70	14%	61/71	86%
First-time takers	61	8/61	13	53/61	87	61	8/61	13	53/61	87
Repeat candidates	6	3/6	50	3/6	50	10	2/10	20	8/10	80

Table 3: Geographic/gender distribution

Total current diplomates = 1,444	Male	%	Female	%	All	%
Active U.S.	1,055	73.06%	117	8.10%	1,172	81.16%
Active international	67	4.64	5	0.35	72	4.99
Retired U.S.	185	12.81	2	0.14	187	12.95
Retired international	5	0.35	0	0.00	5	0.35
Status/address unknown	5	0.35	0	0.00	5	0.35
Expired certificate holders	<u>3</u>	<u>0.21</u>	<u>0</u>	<u>0.00</u>	<u>3</u>	<u>0.21</u>
Total	1,320	91.41%	124	8.59%	1,444*	100%

*This figure excludes diplomates who are deceased

Reexamination fee: Fees for reexamination are the same as shown above for each examination.

Withdrawal from examination: A candidate who fails to appear for examination or who withdraws without giving at least 10 days notice will forfeit \$200 (previously \$100) of the designated examination fee and will have to resubmit the forfeited amount before being admitted to the next scheduled examination.

Late applications: Late applications are those that are postmarked from July 16 through August 15 each year. There is a nonrefundable late appli-

cation fee of \$200 (was \$100), bringing the total processing fee of a late application to \$600. No applications will be accepted postmarked after August 15.

Late examination fees: All examination fees are subject to a late (or past due) assessment of \$200.

Geographic/gender distribution

As of September 2003, the board has a total of 1,444 diplomates: 1,244 in active practice and 200 retired/inactive, three of which have expired certificates. Table 3 on page 43 provides the male/female and international distributions.

The American Board of Obstetrics and Gynecology

by Norman F. Gant, MD, Dallas, TX

No “board eligible” status

The phrase “old myths die hard” has never been more accurate than today when applied to the term “board eligible.” The American Board of Obstetrics and Gynecology (ABOG) last used the term in 1976. Despite this change that was made almost three decades ago, the term is still in common use.

In order to relegate this myth to posterity and to update our diplomates, a listing of current types of board status is outlined herewith. It also must be stressed that all other 23 member boards of the American Board of Medical Specialties (ABMS) have discarded the use of a “board eligible” status. The term is now meaningless. Today, any licensed physician who has completed an Accreditation Council on Graduate Medical Education-approved residency in obstetrics and gynecology is eligible to apply for ABOG examinations leading to certification. The types of board status follow:

Registered graduate. Individuals are registered graduates with the board when, upon application, the board rules that they have fulfilled the requirements to take the written examination.

Active candidate. Individuals achieve active candidate status by passing the written examination. To maintain active candidate status, candidates must fulfill all requirements for admission to the oral examination and must not have exceeded the

limitations to admissibility for the oral examination (six years since passing the written examination or three attempts). Active candidate status that has expired may be regained by repeating and passing the board’s written examination.

Diplomate. Individuals become diplomates of the board when the written and oral examinations have been satisfactorily completed and the board’s certifying diplomas have been awarded. Certificates have a limited duration of validity (six years).

Expired certificate. Individuals have an expired certificate status when they have failed to complete successfully a maintenance of certification process prior to the expiration date printed on their time-limited certifying diploma. Individuals in this category are no longer diplomates of the ABOG. Former diplomates whose time-limited certificates have expired may regain diplomate status by successfully completing an ABOG maintenance of certification process.

Retired diplomate. Individuals have retired from clinical practice at a time when they were still diplomates. Individuals in this category are retired diplomates. If they return to active practice after their time-limited certificate has expired, they must complete an ABOG maintenance of certification program in order to reactivate their diplomate status. Individuals choosing to be retired diplomates must notify the board. Failure to take this

action will result in an expired certificate status.

Exam results

The principal written examination was administered June 24, 2002, at multiple sites.

A total of 1,643 candidates applied for the exam. Of them, 1,209 were new applicants, 1,105 were U. S. medical school graduates (USMGs), 88 were international medical school graduates (IMGs), and 434 were reapplying. Of those persons reapplying, 310 were USMGs and 124 were IMGs. Pass/fail results are listed in Table 1 on this page.

The principal oral examination was administered November and December 2002 and January 2003 in Dallas, TX. A total of 1,433 candidates applied for the oral exam: six were disapproved ad hoc; 21 were disapproved based on case list; 74 turned in incomplete-no fee applications; four were no-shows; 43 withdrew from the exam; and 1,285 took the exam. Pass/fail results are listed in Table 2, this page.

Exam trends. 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 2002. The major decrease has occurred in reapplicants.

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, 1,469 in 2001, and to 1,433 in 2002. This likely reflects the decreasing total number of applicants for the principal written examination noted in the years 1998 and 1999.

Subspecialty exams

The written examinations in oncology were administered June 24, 2002, at multiple sites. Of the 83 individuals taking the exam, 68 (82%) passed, and 15 (18%) failed.

Subspecialty oral examinations were administered April 15-17, 2002. In the subspecialty of re-

**Table 1:
Pass-fail results/written examination**

	Passed		Failed	
	#	(%)	#	(%)
Took exam	1,154	(76)	361	(24)
USMGs	1,066	(80)	260	(20)
IMGs	88	(47)	101	(53)
First-time takers	1,037	(89)	132	(11)
USMG first-time takers	957	(89)	114	(11)
Reapplications	117	(34)	229	(66)

**Table 2:
Pass-fail results/oral examination**

	Passed		Failed	
	#	(%)	#	(%)
Took exam	1,119	(87)	166	(13)
U.S. graduates	1,055	(88)	150	(12)
International graduates	64	(80)	16	(20)
U.S. graduates/ first-time takers	954	(89)	113	(11)
The number of active diplomates is 34,000 (approximate).				

productive endocrinology/infertility (REI), 44 individuals took the oral exam, and 34 (77%) of them passed. A total of 886 physicians are board-certified in REI to date. In the subspecialty of maternal-fetal medicine (MFM), 48 individuals took the oral exam, and 38 (79%) passed. A total of 1,457 physicians are board-certified in MFM to date. In the subspecialty of gynecologic oncology (GO), 39 individuals took the oral exam, and 35 (90%) passed. A total of 725 physicians are board-certified in GO to date.

Trends/written exams. The number of applications, those approved to take the examinations, and the actual number who took the subspecialty written examinations in MFM and REI have de-

clined for the past two years. This finding likely reflects the marked decrease in applicants for these fellowship positions first noted three years ago. The marked decrease this year was likely due to the increase in duration of fellowships from two to three years. The pass rate for the written examination in GO has remained stable since the mid-1990s, between 70 and 82 percent.

Trends/oral exams. The pass-fail percentage rates for the subspecialty oral examinations are listed by year from 1990 to 2002 in Table 3, this page.

A total of 3,068 diplomates have been issued subspecialty certificates (GO, MFM, REI) of whom approximately 2,421 are currently in practice. This represents approximately 7.1 percent of the total of 34,000 actively practicing diplomates.

Maintenance of certification

Certificate renewal/voluntary recertification written exams were administered June 24, 2002, at multiple sites. Of those physicians seeking to renew their certificates in obstetrics/gynecology (ob-gyn), 117 (97%) passed and four (3%) failed. Of those physicians seeking to renew their certificates in ob-gyn and GO, four (100%) passed. Of those physicians seeking to renew their certificates in ob-gyn and MFM, eight (100%) passed. Of those physicians seeking to renew their certificates in ob-gyn and REI, seven (100%) passed.

A total of 6,259 individuals applied for annual board certificate (ABC) renewal and voluntary recertification for 2002 in the areas of ob-gyn, oncology, MFM, and REI. A total of 6,239 applications were approved in these subspecialties, seven were disapproved, 13 applications were withdrawn, and 200 were incomplete. Pass-fail numbers and percentages of diplomates who started the ABC process are listed in Table 4, this page.

Analysis of ABC, first five years. For the obstetrics and gynecology portion of the ABC process several points are worthy of note. Approval of applications in the years 1998, 1999, 2000, and 2001 was 97.5, 99.8, 99.7, 99.6, and 99.7 percent, respectively. The number of applications in 1999 (3,292) decreased from 1998 (4,098). This 20 percent decrease likely is explained by individuals who did not complete the process in 1998 and did not apply in 1999, plus the attrition of those individuals who simply did not want to continue the pro-

Table 3: Subspecialty oral examinations: Pass-fail percentage rates 1990-2002

	<u>GO</u>		<u>MFM</u>		<u>REI</u>	
	<u>Pass</u>	<u>Fail</u>	<u>Pass</u>	<u>Fail</u>	<u>Pass</u>	<u>Fail</u>
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
2002	90	10	79	21	77	23

Table 4. Pass-fail numbers/percentages of diplomates who started ABC process

	<u>Approved</u>	<u>Pass</u>		<u>Fail</u>	
	<u>#</u>	<u>#</u>	<u>(%)</u>	<u>#</u>	<u>(%)</u>
Ob-gyn	5,456	5,265	(96)	191	(4)
ONC	139	130	(94)	9	(6)
MFM	435	409	(94)	26	(6)
REI	<u>209</u>	<u>197</u>	<u>(94)</u>	<u>12</u>	<u>(6)</u>
Totals	6,239	6,001	(96)	238	(4)

cess for a variety of reasons. The increase back to 4,092 in 2000, 4,808 in 2001, and 5,742 in 2002 almost certainly represents the influx of another group of diplomates with time-limited certificates choosing this method of certification maintenance. 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. In 2002, this was slightly less than 3 percent. 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. The 2002 value was 38 percent. This decline was expected due to the entry of more diplomates with time-limited certificates.

Analysis of the subspecialties after four 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. This was 99 percent in 2001 and 99.5 percent in 2002.

Since 1999, those failing and/or not completing the subspecialty ABC process appear to have bottomed at approximately 6 to 7 percent.

The subspecialists, using the ABC process in obstetrics and gynecology, have changed from voluntary to certificate renewal. The 1999 voluntary rate was 77 percent, the 2000 voluntary rate decreased moderately to 61 percent, and in 2001 this rate was 55 percent. The voluntary rate in 2002 was 30 percent.

Officers and directors

The ABOG officers for the year ending June 30, 2003, were: Philip J. DiSaia, MD, FACS, president; Kenneth L. Noller, MD, vice-president; Larry C. Gilstrap III, MD, treasurer; Gerson Weiss, MD, chairman of the board; Norman F. Gant, MD, executive director; and William Droegemueller, MD, director of evaluation. Directors included Haywood L. Brown, MD; Mary C. Ciotti, MD; Larry J. Copeland, MD, FACS; Alan H. DeCherney, MD, FACS; Sherman Elias, MD, FACS; Wesley C. Fowler, Jr., MD, FACS; David Gershenson, MD, FACS; Ronald S. Gibbs, MD; Frank W. Ling, MD; Michael T. Mennuti, MD; Roy T. Nakayama, MD; Valerie M. Parisi, MD; Nanette F. Santoro, MD; Robert S. Schenken, MD; Russell R. Snyder, MD; Michael L. Socol, MD; and Morton A. Stenchever, MD.

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

The American Board of Orthopaedic Surgery

by Richard E. Grant, MD, FACS, Washington, DC

During the past four-and-one-half years, the American Board of Medical Specialties (ABMS) has pursued a major revision of policy focusing on physician competence. Accordingly, the American Board of Orthopaedic Surgery (ABOS) has responded to these mandates by developing programs relevant to maintenance of competency.

In addition, the ABOS has recently instituted a new standing committee in order to allow for more effective communication with the American Academy of Orthopaedic Surgery, diplomates of the American Board of Orthopaedic Surgery, and residents who are also facing the challenges of adjusting to the ABMS push for maintenance of certification and enhancement of professionalism.

Additionally, our recertification examination committee, chaired by Randy Rosier, MD, has been evaluating a practice profile examination, which has been offered for several years. The last addition to the practice profile series was the spine surgery examination that came on line in 1999. The practice profile recertification examinations currently offered include adult reconstructive surgery, sports medicine, and spine surgery. The committee has found that approximately 40 percent of the questions presented on the practice profile recertification examination are basic science and general orthopaedic questions. The general written recertification examination was given on February 7, 2003, at the annual meeting of the ABOS

in New Orleans, LA. The oral recertification examination was administered July 8, 2003, in Chicago, IL, and the computerized recertification examination for the general category, adult reconstruction, and sports medicine and spine surgery was made available to diplomates during March and April of 2003. These examinations are administered throughout the country at specified Prometric testing centers. The computerized examination for the certificate of added qualification (CAQ) of hand recertification pathway was reevaluated and reinstated in mid-August and mid-September 2003, to be administered at the Prometric testing centers. The written examination for CAQ hand recertification has been discontinued.

In 2002, a total of 72 candidates took the general written examination and 70 passed. Of 299 candidates who chose the computerized general written examination pathway, 294 passed. Fifty-one candidates took the adult reconstructive surgery examination, and all 51 passed. There were 106 candidates who chose to take the sports medicine examination, and all of these examinees passed. Of the 58 candidates who took the spine surgery examination, 57 passed. Of the 47 candidates who took the CAQ hand pathway, 46 passed.

Finally, of the 50 candidates who chose the oral recertification examination, 42 passed. Of the overall 683 candidates examined in 2002, 666 passed, for a passage rate of 98 percent. The results for the 2003 examination are pending.

Maintenance of certification

The current committee is headed by James Luck, MD, FACS, of Los Angeles, CA. The ABOS has developed an ad hoc committee in conjunction with the American Academy of Orthopaedic Surgery to explore the issues of maintenance of certification. Currently, the ABOS evaluation includes continuing medical education (CME) credits, evaluation of practice performance, and one of the following secure exams:

1. Written general examination.
2. Computer-based general examination.
3. Computer-based practice profile examination in adult reconstruction, spine, and sports medicine.
4. Practice-based oral examination based on

a six-month case collection from the candidate's practice as with the Part II oral examination.

5. Certificate of added qualification for hand surgery, now administered at the Prometric center.

The ABOS committee addressing the issues of maintenance of certification has responded to the ongoing concerns from public and private constituents. The ABMS created a task force on physician competency in 1998. The ABMS task force focused on methods to evaluate specialists after completion of initial certification. The information forwarded from the ABMS program has generated a new program for maintenance of certification. The task force identified four essential components of maintenance of certification—ongoing evidence of professional standing, commitment to lifelong learning and periodic self-assessment, cognitive expertise, and evaluation of practice performance.

In 2000, the ABOS and the American Academy of Orthopaedic Surgery established a task force with six members from each organization to address the complex question of how orthopaedic surgery could best respond to the maintenance of certification requirements as defined by the ABMS. In addition, the committee's task force also focused on addressing concerns and issues raised by the ABOS with respect to retesting after years of practice.

The American Academy of Orthopaedic Surgery's survey went out to 1,300 diplomates certified prior to 1992. Nine hundred and seventy-three, or 32 percent, responded. Sixty-seven percent of the respondents agreed that it was necessary to have a system that ensured "competence." Seventy percent of respondents agreed that it should be a documented system and that there was no clear position on the question, "Is the current system effective and fair?"

The ABMS requested that their individual specialty board submit plans for implementation of the first three components of maintenance of competency by February 2003. The ABOS has already submitted its report and that report has been favorably received.

The fourth element of maintenance of certification includes the program for evaluation of practice performance that is to be forwarded to the ABOS by 2004. The purpose of this compo-

ment is to demonstrate to patients, the public, and the profession that physicians provide safe, effective, patient-centered, timely, efficient, and equitable health care.

The goal of the maintenance of certification program is to stimulate continued education and improvement. The greatest challenge that the committee continues to face is the fourth component of the ABMS directive, evaluation of performance in practice.

CAQ/hand surgery

The committee on the certificate of added qualification in surgery of the hand, under the direction of Peter Stern, MD, FACS, provided testing for 75 examinees in 2002. The examinees included 57 registered by the ABOS, 17 examinees registered with the American Board of Plastic Surgery, and one with the American Board of Surgery. This compared favorably with 96 individuals who took the examination in 2001, 103 in 2000, and 75 in 1999. Overall, 24 percent of the examinees reported that their practice was devoted exclusively to hand surgery and 82 percent indicated that at least 75 percent was devoted to hand surgery. Sixty-nine percent had an annual case load of more than 250 hand cases. The passing score of 65 percent was chosen. Two of the three reexaminees failed and failure rates for the computer-administered and written examinations were comparable.

The CAQ in surgery of the hand report for recertification indicated that a total of 109 examinees took the recertification examination. Sixty-seven percent of the examinees were from the ABOS, 26 percent from the American Board of Plastic Surgery, and 13 percent from the American Board of Surgery. There was one reexaminee for recertification. Eighty-three percent of the examinees took the computer-administered examination at one of the local Prometric testing facilities and 17 percent took the written examination in Rosemont, IL.

Based on the equating study results and the 2002 certification examination passing score, a passing score of 63 percent was chosen. A total of 98 examinees passed and 11 failed, for an overall failure rate of 10.1 percent.

For 2003, both the certification and recertification examinations for CAQ of the hand will be

entirely computer-based and will be administered by a local Prometric testing center. The paper and pencil written examination has been discontinued. By 2004, the ABOS diplomates who wish to recertify in orthopaedic surgery and continue to maintain a certificate of added certification will have to pass a combined computer-administered examination consisting of approximately 160 CAQ questions and 80 general orthopaedic surgery questions.

Research committee

The ABOS research committee is chaired by William E. Garrett, MD, FACS, in conjunction with Mark F. Swiontkowski, MD, FACS. The research committee continues to work on three separate projects. The ABOS began working on the development of a virtual reality model for simulation of knee arthroscopy. The ABOS has continued to work in conjunction with the American Academy of Orthopaedic Surgery and the Arthroscopy Association of North America to continue the development of a virtual knee arthroscopy simulator and psychomotor skills testing module.

The committee also continues to pursue methods of incorporating patient-derived outcome studies and data into the certification process. Dr. Swiontkowski and Dr. Garrett have instituted pilot studies not dissimilar to the academy's previous experiments with modems outcomes forms and short-form musculoskeletal functioning assessment forms. The research committee feels that the process can be linked to the patient list provided by ABOS candidates for the oral examination. This will allow the candidates to provide subjective patient data to be correlated with the candidate's self report of their clinical outcomes and results.

A second pilot study utilizing patient-derived outcomes data has also been undertaken. Oral examination Part II applicants were offered the opportunity to enroll in the second phase pilot test.

Over the past three years, the ABOS research committee has collected data on the diagnosis and procedures for all cases completed by candidates presenting for Part II of the ABOS examination process. During 2002, there were 718 candidates who performed 92,307 cases in the

six months of data collection. The candidates reported an average of 129 cases. These data have been remarkably similar for the past four years of data collection. The top procedures include knee arthroscopy with partial meniscectomy, carpal tunnel surgery, removal of support implant, knee arthroplasty and chondral debridement, shoulder arthroscopy and decompression, total knee replacement, knee arthroscopy and anterior cruciate ligament reconstruction, repair of thigh fracture, and total hip replacement.

The research committee has also pointed out that the current data lend themselves to monitoring changes in a surgeon's practice over a period of years from immaturity to maturity. These data can help not only with design of the testing procedures for Part I and Part II of the ABOS examination but also in designing a resident education curriculum reflective of current profile trends.

The American Board of Orthopaedic Surgery Committee on Graduate Medical Education is chaired by Mark C. Gebhardt, MD, FACS, of Boston, MA. The residency review committee (RRC) met in South Carolina in conjunction with the proceedings of the American Orthopaedic Association in June 2003. During the meeting the RRC examined 38 orthopaedic residency programs. Two of those programs were placed on probation and one program had its accreditation withheld. Two programs received continued provisional accreditation and 23 attained continued full accreditation.

Thirty-eight fellowships were reviewed and one program in musculoskeletal oncology was placed on probation. There were five proposed adverse actions. Two programs had proposed withdrawal of accreditation, including a program with hand and sports medicine.

In addition to the review of orthopaedic programs and subspecialties, the RRC also tackled the very difficult challenge of reduced resident duty hours. The work group provided its report regarding the implementation of limitation of work hours (that is, 80 hours per week with the option of a 10 percent exception outside of New York State). The committee also discussed antitrust litigation directed toward the NRMP and ACGME.

Several concerns regarding graduate medical education have been identified by the ortho-

paedic RRC, including limited program director retention and acting chairmanships.

Written examination

The ABOS written examination committee reported the results of their examination process. In 2002, of the 805 examinees, 79 percent passed and 21 percent failed. Of the 623 examinees who were taking the examination for the first time, 89 percent passed and 11 percent failed.

The question writing in field task forces, the National Board of Medical Examiners, and the ABOS written examination committee are involved in the creation of the written examination. The process of developing the written examination requires the activities of 50 orthopaedic surgeons representing all subspecialties of orthopaedic surgery working for a period of at least two years.

The 2002 examination contained 321 items. Twenty-five items were identified as potentially defective by preliminary item analysis during the key validation process. The passing standard on the 2002 written certifying examination was 1.13 logits on the Rasch Bank scale. The 2002 examination standard was equivalent to a percent correct of 67.8 percent.

Credentials committee

During the 2002 meeting, the ABOS credentials committee reviewed 24 of the 700 recertification applicants and accepted 12 of those reviewed for the 2003 recertification examination process. Two were denied, five were deferred, and site visits were recommended for two applicants.

Recertification was adopted by the ABOS in 1972 and, beginning in 1986, all certificates issued by the ABOS were time limited to 10 years. The ABMS, of which the ABOS is a member, had endorsed maintenance of certification that will replace the concept of recertification.

The credentialing process is dependent upon the ABOS diplomates participating in the candidate evaluation process. The candidate has waived the right to take action for practice information provided in good faith. Additionally, state laws usually protect peer review information provided in good faith. ABOS liability insurance covers diplomates providing peer review

information that is factual, accurate, and given in good faith. The candidate evaluation process provides the basis for the ABOS evaluation of continued demonstration of the applicant's professional competence and adherence to acceptable ethical professional standards.

During the credentials committee meeting in March 2002, 33 of 736 applicants for the Part II examination were reviewed. Twenty were allowed to sit for the examination, 13 were deferred, and 98 percent of the candidates were recommended to the board to sit for examination.

The recertification credentialing process is similar. Candidate evaluations are requested from certified orthopaedic surgeons who are familiar with the work of the applicant but not associates. The hospital administrator for each hospital where the applicant practices or has practiced must send a notarized letter verifying staff privileges and dates of practice. Continuing medical education Category 1 documentation for the prior three years must be provided by the candidate. In a manner similar to the credentialing process for Part II, the credentials committee provides recommendations to the board for admission to the recertification process. Adverse actions can include deferral or rejection of that application.

Oral examination

The ABOS oral examination committee is currently chaired by John J. Callahan, MD, of Iowa City, IA. The Part II oral examination administered in Chicago, IL, in July 2003 hosted well over 700 candidates who had previously passed the Part I examination.

The Part II oral examination is a practice-based examination. The candidate is asked to present 10 cases selected from his practice based upon a six-month computerized case list. The total number of operative cases for the 700-plus candidates was well over 100,000. The case list submitted to the board is reviewed by the directors of the board and selected oral examiners to identify 12 potential cases for examination. The ABOS now has an Internet-based selection system, Scribe. Scribe has been functioning well for the past four years and simplifies the selection of cases for the candidates.

The examination is a one-hour-and-45-minute practice survey divided into three 35-minute segments, with a five-minute break between each testing session. During each segment, the candidate is examined by two examiners who are matched to the candidate for areas of stated expertise. The examiners are provided the complete case list as well as a graphic analysis of the candidate's practice profile and complications.

The decision with respect to passing or failing the candidate is based upon performance as assessed independently by six examiners without any caucus of the examiners. For each case presented, a candidate is graded on data gathering, diagnosis, treatment, planning, technical skills, outcomes, and ethics. At the conclusion of the examination process, each candidate has received approximately 100 to 130 grades that are statistically averaged and adjusted based upon the known severity or leniency of the examiner.

In contradistinction to Part I written examination, which tests exclusively orthopaedic knowledge, the Part II oral examination tests the application of that knowledge, diagnostic acumen, surgical techniques, outcomes, and ethics.

The oral examination committee has encouraged constructive debate to consider the most effective mechanism to measure the components of maintenance of competency for diplomates who have been in active practice. Consideration has been given to expansion of the oral examination process, review of practice generated case lists, and directed CME.

The American Board of Surgery

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

The following report summarizes the events of the 2002-2003 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.

Initiation of early specialization program

After 12 months of preparation and comment, the ABS, in January 2003, adopted the early specialization program for vascular and pediatric surgery. The program will allow residents in an institution with residencies in either of these specialties plus general surgery to have an integrated program in which they will enter specialty training after the PGY-4 year. The chief year of general surgery will be completed in the PGY-4 year, and the PGY-5 year, which will be the first year of specialty training, will also count as a fifth year of general surgery. The program will allow residents to complete training in six years and be eligible for both the general surgery and specialty certificates.

Initially the program will only be implemented in a single institution although, as experience is gained, it is envisioned that residents will be able to move between institutions for general surgery and specialty training. The program will be operating on a pilot basis initially, with outcome measures being maintenance of the number and diversity of total cases, as well as those in the defined categories of the residency review committee for surgery (RRC-S). Impact on those individuals entering the program, as well as other residents in the program, will be assessed and the ability of participants to maintain first-time pass rates on the qualifying and certifying examinations will also be monitored.

The program was reviewed by the RRC-S in February 2003 and approved. An oversight committee of representatives from the ABS and the RRC-S has been appointed under the chairmanship of J. David Richardson, MD, FACS, and is currently in the process of developing specific guidelines and implementing the program. It is envisioned that applications will be received by the RRC-S this fall,

and the first residents may enter the program at the PGY-4 level in July 2004.

Computer-based recertification exams

The board moved progressively toward computer-based examinations for recertification, beginning in October 2003, with the specialty areas of vascular surgery, pediatric surgery, and surgical critical care. The surgery of the hand certification and recertification examinations have been given in computer-based formats since August of 2002. A vendor has been selected—Pearson Vue—which operates professional testing centers available throughout the country. There are a total of 200 professional centers so, from any given location, a diplomate taking the recertification examination will likely have to travel no more than 50 miles to locate a center.

In addition, the window during which the examination may be scheduled will extend over two weeks at the end of October, so that the diplomate may schedule more conveniently than before. Some of these centers will also be available on a Saturday schedule. The actual format of the examination—that is, multiple-choice questions with five possible answers—will remain the same as the paper and pencil version.

This change has been made to increase the convenience for diplomates in scheduling time for the examination and in decreasing travel costs and time away from home. It was well received by those taking the surgery of the hand examination last year, and we anticipate the same advantages for the larger group this year. In October of 2004, we anticipate extending this process to those diplomates who will be recertifying in surgery.

IT/SBSE suspicious matches

In the ABS report to the College last year, we highlighted a distressing finding that has occurred in the past few years. The ABS uses software that detects cheating on multiple-choice examinations by comparing the answers of all persons taking the examination with all others. The identifica-

tion of cheating occurs when two candidates have a high percentage of the same wrong answers to the questions. Since each question has four possible wrong answers, the likelihood of a substantial match between two candidates (>50% agreement) is unlikely by coincidence. The software allows the level of probability to be adjusted and, in the use of the software to monitor our examinations, it has been set at the $p < .0000001$ (1 in 1 million) level.

As we noted last year, there have been 30 to 50 episodes of cheating identified per year for the last four years, despite admonitions to program directors. In 2002, 38 episodes were identified, usually involving two persons, and occasionally three.

In 2003, the board printed the In-Training/Surgical Basic Science Examination (IT/SBSE) in two versions. Each had the same questions, but they were in different order in the two versions of the test booklet. Program directors were asked to hand alternate versions of the booklet to test takers seated next to each other, so that copying from one to the other would be difficult. With this modification, the incidence of cheating episodes dropped to 12 this year, but was not completely eliminated.

The board has notified all program directors of affected programs and has recommended specific measures to reduce the likelihood of cheating in the future. It has been found that the most effective measures are assigned rather than random seating, adequate spacing of candidates, and careful proctoring. The board has adopted specific policies for dealing with programs in the future when cheating episodes are identified in more than one year. After the first year, the program director and chief of surgery will be notified. If cheating occurs for a second year, the notification will go to the program director, chief of surgery, and the director of graduate medical education (GME) of the facility, with a requirement that the GME committee adopt specific measures to prevent future occurrences and report back to the board. If cheating occurs for a third year, use of the IT/SBSE will be withheld from the institution.

The same monitoring software has been applied to the qualifying examinations and the recertification examinations in all specialty areas and no cheating episodes have been detected in these venues.

Maintenance of certification initiative

The ABS has previously adopted the maintenance of certification (MOC) initiative of the American Board of Medical Specialties (ABMS), and is in the process of implementing its requirements, with the help of the ACS. 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 is evaluated by the requirement of a full and unrestricted license in all jurisdictions where licenses are held by a diplomate, and by personal reference letters 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 continuing medical education (CME) activities in the two years prior to submission of the recertification application, of which 60 hours must be Category 1.

The third requirement is met by taking and passing the recertification examination of the ABS.

The fourth requirement is met 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 surgical oncology advisory council (SOAC), which are geared to obtaining outcomes measures that could be used in the MOC process. In 2003, for the first time, recertifying diplomates in vascular surgery are submitting reports of their outcomes with three operations: carotid endarterectomy, aortic aneurysmectomy, and infrainguinal bypass. Complication rates for each are being reported by all candidates as a condition of recertification. The reporting of complications is required with submission of the recertification application, but contains no identifiers and is separated from the basic application after it reaches the board office so that there is no way in which these records could be subject to discovery. As we gain experience in this area, we anticipate developing some norms of

**American Board of Surgery
Summary of 2002-2003 examinations**

Examination	# of Examinees	Pass rate	Diplomates to date
Qualifying	1,285	75%	
Certifying	1,184	83	48,355
Recertification	1,355	97	13,736
Vascular surgery qualifying	123	85	
Vascular surgery certifying	126	83	2,259
Vascular surgery recertification	146	97	1,214
Surgical critical care certification	78	90	2,009
Surgical critical care recertification	129	94	808
Pediatric surgery qualifying	--	--	
Pediatric surgery certifying	--	--	877
Pediatric surgery recertification	--	--	498
Hand surgery certification	1	100	224
Hand surgery recertification	14	86	75
Pediatric surgery ITE	69	N/A	N/A
IT/SBSE	<u>7,323</u>	N/A	N/A
Total	11,833*		

N/A = Not applicable.
*4,441 examinees, excluding the IT/SBSE and pediatric surgery ITE.

reported experience and sending this information back to all diplomates for them to compare their own statistics so as to facilitate peer review at the local level.

We have not yet initiated such a program for recertification in surgery but are currently looking at various alternatives. The board feels it is essential for diplomates to begin some form of practice outcomes assessments for the more common procedures they do in order to meet the requirements of the fourth component of MOC.

The American College of Surgeons has been helping greatly with this process through the establishment of the task forces this past year to examine the various competencies, and we anticipate collaborative efforts with them in developing practical and workable measures. We anticipate that the ABMS will require implementation of all four components of MOC within the next one to two years.

Independent vascular surgery board

The American Board of Vascular Surgery (ABVS) applied for independent board status with the ABMS last year, and the application was heard by the Liaison Committee for Specialty Boards (LCSB) in December 2002. The LCSB denied the application, and the ABVS has decided to appeal the decision. A new committee will re-review the application and render a new judgment, but the timetable for that process has not yet been set.

Meanwhile, the VSB-ABS continues to work effectively to advance the interests of the vascular surgery community and to improve the certification process for vascular surgery. The VSB-ABS has complete responsibility for determining the requirements for vascular surgery certification and for developing the vascular surgery qualifying, certifying, and recertification examinations. The quality of the oral examinations has

been enhanced with the addition of objective visual and diagnostic material to nearly all prompter cases, and the oral examination process has been improved with the designation of a senior examiner group who will serve specific terms as vascular surgery examiners.

G. Patrick Clagett, MD, FACS, served as chair of the VSB-ABS from its inception until completion of his term on the ABS in June 2003, and has done an outstanding job of leading the vascular surgery board through its organization and initial work. He received the commendation of the full board for exemplary service during his six-year term. The chairmanship of the VSB-ABS has now been assumed by Frank W. LoGerfo, MD, FACS, of Boston, MA.

The ABS continues to oppose the designation of the ABVS as an independent board, and believes the VSB-ABS has done an outstanding job of representing vascular surgery. It is the belief of the board that vascular surgery represents an essential content area of general surgery and that the teaching of vascular surgery to general surgery residents remains crucial to their training, whether they choose to enter vascular surgery as a specialty area or not. Virtually all areas of general surgery and its specialties require a basic knowledge of vascular surgery, and the separation of this discipline from general surgery training would be a crucial error.

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 2003: (ABS directors) G. Patrick Clagett, MD, FACS; Thomas M. Krummel, MD, FACS; Mark A. Malangoni, MD, FACS; Bradley M. Rodgers, MD, FACS; Luis O. Vasconez, MD, FACS; (VSB-ABS) Bruce J. Brener, MD, FACS; and (SOAC) Peter W. T. Pisters, MD, FACS.

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

ABS directors: E. Christopher Ellison, MD, FACS, American College of Surgeons; Carlos A. Pellegrini, MD, FACS, American Surgical Association; James A. Schulak, MD, FACS, American Society of Transplant Surgeons; Marshall Z. Schwartz, MD, FACS, American Pediatric Sur-

gical Association; Thomas R. Stevenson, MD, FACS, American Board of Plastic Surgery; and Jonathan B. Towne, MD, FACS, Joint Committee for Vascular Surgery.

VSB-ABS: John J. Ricotta, MD, FACS, American Association for Vascular Surgery

SOAC: John M. Daly, 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 individual who will retire from active examiner status this year: David M. Heimbach, MD, FACS.

Necrology

It is with great regret that we report the deaths of the following individuals during the past year: Richard J. Cleveland, MD, FACS (June 11, 2002); Gustaf Lindskog, MD, FACS (August 4, 2002); Ronald A. Malt, MD, FACS (October 5, 2002); Marshall K. Bartlett, MD, FACS (December 14, 2002); David B. Skinner, MD, FACS (January 25, 2003); James D. Hardy, MD, FACS (February 19, 2003); William P. Longmire, Jr., MD, FACS (May 9, 2003); and James H. Foster, MD, FACS (June 17, 2003).

The American Board of Thoracic Surgery

by Timothy J. Gardner, MD, FACS, Philadelphia, PA

New inactive status

Diplomates holding a valid certificate from the American Board of Thoracic Surgery (ABTS) and who expect to be clinically inactive for a period of one year or more may apply for inactive status. Applications must be made in writing to the board, and approved before the granting of inactive status. Activities calling for such status might include, but are not limited to, academic sabbaticals, advanced studies, elected/appointed political offices, temporary disability from illness, or appointment to administrative positions in hospitals, medical schools, or health-related industries.

There is no limit to the length of time that a diplomate can remain on inactive status, but by applying for inactive status, the diplomate certifies that he/she will refrain from the clinical practice of thoracic surgery for the entire duration of the inactive status. For more information on the new inactive status policy, visit the board's Web site at www.abts.org.

Recertification policies

In response to an initiative by the American Board of Medical Specialties, the ABTS, along with the other medical certifying boards, has begun the transition towards a Maintenance of Certification Program®. Beginning in 2001, the ABTS changed some of its recertification policies. All diplomates should be aware of the changes in the requirements in anticipation of renewing their own certificates. The board feels that recertification is important to the public and to each physician's professional career.

A valid ABTS certificate is an absolute requirement for entering the recertification process. The only pathway for renewal of a lapsed certificate will be to take and pass the Part I (written) and the Part II (oral) certifying examinations. The ABTS will no longer publish the names of individuals who have not recertified.

The deadline for submitting recertification applications is now May 10 of each year. The change will now allow diplomates to include continuing

medical education (CME) hours earned from attending medical meetings that are held in the spring. Additionally, diplomates need to be in compliance with the annual certification maintenance fee in order to enter the recertification process. The CME requirement is 70 Category 1 credits in either cardiothoracic surgery or general surgery earned during the two years prior to applying for recertification. Additional information concerning recertification requirements can be found in the annual *Recertification Booklet of Information*.

In 2002, 230 diplomates recertified, of which 126 did so for the first time and 104 for the second time. One hundred seventy-three diplomates used the SESATS computer version and 57 diplomates used the paper and pencil version (see table, page 57).

Background

Diplomates certified after 1975 must recertify within 10 years of the date of the original certification in order to maintain their certification. Diplomates with time-limited certificates may apply within three years of the expiration of their certificate.

Diplomates of the Board of Thoracic Surgery and the ABTS who were certified prior to 1976 do not require recertification and are considered to hold unlimited certificates.

The annual certification maintenance fee is required of all active diplomates, age 65 and under. The cumulative fee helps defray administrative expenses related to maintaining and using the diplomate information on the board's computer system. The board will not respond to inquiries about the diplomate's certification status until the fee is paid each year.

Examinations

On November 24, 2002, the board administered its tenth criterion-referenced Part I (written) exam to 155 individuals. The pass rate for the examination was 86 percent. By using a criterion-referenced test, candidates are measured against a standard of knowledge predetermined by the board rather

**ABTS recertification activity
(current through 2002)**

Date of orig. cert.	Total # cert.	Total # recert. first time	% recert.	Total # recert. second time	% recert. second time
Prior to 1976	N/A	66	--	4	--
1976	160	142	89	128	80
1977	146	129	88	108	74
1978	154	141	92	119	77
1979	158	147	93	121	77
1980	110	100	91	90	82
1981	131	124	95	111	85
1982	159	147	92	126	79
1983	136	122	90	74	54
1984	135	125	93	44	33
1985	120	119	99	--	0
1986	147	140	95	--	0
1987	141	137	97	--	0
1988	136	129	95	--	0
1989	159	155	97	--	0
1990	122	114	93	--	--
1991	122	118	97	--	--
1992	142	139	98	--	--
1993	141	97	69		
1994	156	57	37		

than against each other, as in the case of a norm-referenced examination.

The board administered its seventh criterion-referenced Part II (oral) examination to 138 individuals on June 6-7, 2003. The pass rate for the examination was 85 percent. By using a criterion-referenced exam, the board applies statistical methods to equate the examination, so that alternative forms of the examination are compared to a single standard. The basic premise of a criterion-referenced exam is that all candidates have a comparable opportunity to pass since they are measured against the same standard.

New pathways/requirements certification

On October 20, 2001, the ABTS approved the following resolutions regarding thoracic surgery certification. The exact timing of implementation for some of the resolutions has yet to be determined.

1. Certification by the American Board of Surgery (ABS) is optional rather than mandatory for residents who begin their thoracic surgery training in July 2003 and after.

2. One pathway to ABTS certification will consist of successful completion of a full general surgery residency approved by the Accreditation Council on Graduate Medical Education (five years) or the Royal College of Physicians and Surgeons of Canada, with or without ABS certification, followed by successful completion of a two- or three-year ACGME-approved thoracic surgery residency. Individuals entering thoracic surgery residencies in July 2003 or after will be eligible under this pathway.

3. A second pathway to ABTS certification will be a categorical-integrated six-year thoracic surgery residency, to be developed by the Thoracic Surgery Directors Association (TSDA). Residents

in these programs will be under the direction of the thoracic surgery program directors. Before this pathway is implemented, the residency review committee for thoracic surgery (RRC-TS) must first approve the standards and requirements for such programs. Individuals will match for such programs directly from medical school or at some later time. It is estimated that the first such programs would begin to accept residents in 2004 at the earliest.

4. A third pathway to ABTS certification will be through successful completion of an ACGME-approved three-year thoracic surgery residency after a minimum of three years in an ACGME-approved general surgery residency, so long as certain prerequisite criteria are met during the general surgery training. These prerequisites include:

General surgery: (including six months abdominal surgery and six months pediatric, oncology, and head and neck surgery)	12 months
Critical care:	2 months
Transplantation and immunology:	2 months
Trauma:	2 months
Cardiothoracic surgery:	3 months
Vascular surgery:	<u>3 months</u>
Total:	24 months

It is estimated that such programs would begin to accept residents in 2005 at the earliest.

5. Any individual currently in the ABTS certification process (that is, in a thoracic surgery residency or has already finished a thoracic surgery residency) will be guided by the requirements in force at the time of his or her residency.

6. The ABTS supports the following recommendations of the Joint Council for Thoracic Surgery Education (JCTSE):

a. The JCTSE strongly encourages the RRC-TS as part of the special requirements for thoracic surgery residencies to require documentation of faculty participation in medical school curriculum.

b. The JCTSE strongly encourages the ABS and Association of Program Directors in Surgery (APDS) to develop a shorter curriculum in "sur-

gery"—to include ABS certification that, if and when approved, would permit an alternate pathway to ABTS certification.

c. The JCTSE strongly encourages the ABS and APDS to participate in the development of a surgical preparatory core curriculum as a standard entry to ACGME boarded surgical specialties.

Interested parties should take particular note that the categorical-integrated program and the 3/3 program mentioned above have yet to be fully developed and will require approval action by the RRC-TS before they become available. The ABTS is committed to working closely with the ABS and other organizations in general surgery toward the development of combined 4/3 programs leading to the possibility of certification by both the ABS and the ABTS.

Applications

The deadline for submitting applications for certification is August 1 each year. The ABTS is no longer able to accept applications pending certification by the ABS. All requirements must be fulfilled at the time the application is submitted.

All residents who begin their training in 2001 or after must file their application and operative cases logs electronically through CTSNet. The board will allow residents who began their training in 2000 to file their cases through CTSNet (electronically) or by submitting a paper version. The board urges the program directors to help their residents in the application process by carefully reviewing the application before signing it.

Booklet of Information

Published annually, the *Booklet of Information* contains information about how the operative index case requirements should be recorded and tracked, which now has two components: surgical volume and index case distribution. All residents must perform an annual average of 125 major operative cases each year with a minimal number of 100 in any one year. Effective July 1, 2002, the board approved changes to the index of operative cases requirements for all candidates, which can be found in the latest *Booklet of Information*.

In-training examination

The 2003 in-training exam was held April 5 and April 12. A total of 353 individuals took the examination that was administered only online. The in-training examination consists of 80 general thoracic and 80 cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination. Score reports and comparative results were posted on the Internet for all test takers. The board encourages program directors and residents to use the in-training examination as an educational and self-evaluation tool.

Public education brochure

The public education brochure, *Your Surgeon Is Certified by the American Board of Thoracic Surgery*, continues to be available for purchase through the board office.

New board members

At the 2002 fall board meeting, Valerie W. Rusch, MD, FACS, was elected to replace outgoing director William A. Baumgartner, MD, FACS, to represent the American Surgical Association on the board. □