

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* contains 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* featured the 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 October 3, 2004, and its most recent interim meeting March 21, 2004, both at the Omni Hotel in Chicago, IL. Future meetings will be held at the Omni Hotel through 2007. The schedule is as follows:

Written examination/interim meeting: March 19-20, 2005, March 25-26, 2006, and March 17-18, 2007.

Oral examination/annual meeting: September 23-25, 2005, September 29-October 1, 2006, and September 28-30, 2007.

Officers/members of the board

The board is composed of 14 members. Nominations to fill vacancies come 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 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: Alan G. Thorson, MD, FACS, president; Vendie H. Hooks, 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; James W. Fleshman, 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; Steven D. Wexner, MD, FACS; Bruce G. Wolff, MD, FACS; and W. Douglas Wong, MD, FACS.

Examination committee activities

Dr. Fleshman chairs the board's examination committee. It is divided into three working groups consisting of the written, oral, and maintenance

of certification subcommittees; each is directed by a separate chairperson. At the March 2004 board meeting, new committee members were chosen. Dr. Wolff was selected to serve as the new examination committee chairman with Dr. Roberts as the written examination committee chair. Because Dr. Fleshman's term will expire following the September 2005 board meeting, the subcommittee chairs will serve concurrently with the current chairs to ensure a smooth and uninterrupted transition. A summary of the committee's 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. Ultimately, the 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 process more objective and provide a mechanism that better identifies candidates' shortcomings. Following the October 3, 2004, annual board meeting, the following changes or refinements were made to the oral examination process:

- Written summaries will replace oral critiques. The new procedure will provide failing candidates with a more comprehensive summary and relieves the evaluator of a difficult task. The written summaries will include information advising candidates to address any additional questions within 30 days after receipt of the original performance summary, in writing, to the board office. If a decision is made to grant the request, candidates will be assigned to the appropriate individual for follow-up.
- Candidate surveys conducted. Beginning with the October 2, 2004, oral exam, all candidates were asked to complete a questionnaire regarding the oral examination process. The board is tallying the responses and looks forward to receiving some constructive comments and useful information regarding its exam process. In 2005, the survey will be expanded to obtain additional details about examiners' performance. The information

Table 1: ABCRS recertification performance - 1991-2004

Year	Participants	Passed	Percent	Failed	Percent	Maximum	Minimum	Average
2004	46	33	72%	13	28%	94%	59%	75%
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>
Totals	351	323	92%	28	8%	98%	57%	85%

Passing score: 70 percent

Table 2: Examination results: Pass/fail rates

	Written exam - March 20, 2004 (71 candidates)					Oral exam - October 2, 2004 (71 candidates)				
	#	Fail		Pass		#	Fail		Pass	
		rates	%	rates	%		rates	%		
Total candidates	71	10/71	14%	61/71	86%	71	10/71	14%	61/71	86%
First-time takers	60	8/60	13	52/60	87	60	8/60	13	52/60	87
Repeat candidates	11	2/11	18	9/11	82	11	2/11	18	9/11	82

Table 3: Geographic/gender distribution

Total current diplomates = 1,504	Male	%	Female	%	All	%
Active U.S.	1,091	72.54%	129	8.58%	1,220	81.12%
Active international	64	4.25	5	0.33	69	4.58
Retired U.S.	193	12.83	4	0.27	197	13.10
Retired international	5	0.33	0	0.00	5	0.33
Status/address unknown	6	0.40	0	0.00	6	0.40
Expired certificate holders	<u>7</u>	<u>0.47</u>	<u>0</u>	<u>0.00</u>	<u>7</u>	<u>0.47</u>
Total	1,366	90.82%	138	9.18%	1,504*	100%

*This figure excludes diplomates who are deceased.

will not be used to determine examiner eligibility, but rather, to make improvements to the exam.

- E-mail notification of oral examination results. The October 2, 2004, oral examination results were e-mailed to all candidates the first Tuesday following the exam. The information was transmitted to all candidates who provided accurate e-mail information.

Written examination. Dr. Wolff, chairman of the written examination committee, reorganized the radiology and pathology sections of the written examination into one visual diagnostic examination (VDE), which was offered for the first time during the March 2004 written examination. The VDE combined elements of radiology and pathology into 40 questions incorporating gross and endoscopic photos, various diagnostic studies, and histology. Overall, it covered the gamut of colon and rectal surgery ailments, and the board felt it was very successful.

The board believes these changes make the examination more specialty-relevant. The images and corresponding cases more closely resemble “real life” scenarios and authentic practice settings germane to colon and rectal surgery. The examination was projected using contemporary digital equipment, which facilitated the interpretation of material.

Recertification examination. The last recertification examination was given May 8, 2004, in Dallas, TX. Forty-six diplomates participated; 33 passed and 13 failed.

The results and statistical summaries for 2004 as well as the prior 13 years are provided in Table 1 on page 29.

Transition to MOC

At the board’s March 2003 interim meeting, the recertification committee was officially renamed the maintenance of certification committee (MOC), and it is chaired by Dr. Hooks. Under his direction, the ABCRS is transitioning from recertification to maintenance of certification.

The American Board of Medical Specialties (ABMS) developed the concept of maintenance of certification. This action requires the ABCRS and other boards to approach the entire recertification process with a fundamentally different philosophy. Recertification must be viewed as a continuous process over a period of time, rather than as a one-

time procedure. Beyond changing the focus of recertification, today, there is a growing need to document physician competency for licensure, membership in various health plans, and reimbursement.

The ABCRS MOC plan requires a 10-year interval between the initial certification and completion of requirements to maintain certification for the first time and for each subsequent 10-year interval. The MOC approach evaluates four basic components: professional standing, lifelong learning and self-assessment, cognitive expertise, and practice performance.

The ABMS approved our application for the first three components, and we are now dealing with how to assess the more difficult fourth component, practice performance. It will require the development of a concise, step-by-step plan for assessing physician practice performance. The board has partnered with the American Society of Colon and Rectal Surgeons (ASCRS) to develop this assessment methodology.

The real purpose of moving from recertification to maintenance of certification is to improve patient care, and the ABCRS is focusing on this goal.

Electronic operative log

The ACGME has been attempting to develop an electronic operative reporting system and has requested that the ABCRS participate in the process to make Accreditation Council on Graduate Medical Education and board data more compatible. In September 2003, the residency review committee (RRC) submitted a request for consideration to the board. The document set forth the advantages of the system and provided details for the establishment of procedures. Subsequently, an ad hoc committee, chaired by Dr. Madoff and including Dr. Thorson and Dr. Luchtefeld, was appointed to explore the feasibility of the proposal and to investigate whether a joint ABCRS/ACGME electronic operative log would be compatible with the needs of both groups. The committee has had several discussions and, as of February 2004, it was agreed that a Web- or palm-based system would simplify data collection and that, provided both diagnosis codes and procedure codes were recorded, data could be manipulated into any format that meets the information needs of the board, RRC, and personal digital assistant. In general, the committee indicated that the proposal would

be feasible. A meeting to work out details of this process took place in April 2004 at the ACGME office in Chicago. The tentative goal is to make the transition to an electronic operative transmittal process by July 2006.

Examination results

The most recent written examination (Part I) was given March 20, 2004; 71 candidates were examined. The most recent oral examination (Part

II) was given October 2, 2004; 71 candidates were examined. The pass/fail rates are shown in Table 2 on page 29.

Geographic/gender distribution

As of March 2004, the board has a total of 1,504 diplomates; 1,289 in active practice and 215 retired/inactive, seven of which have expired certificates. Table 3 on page 29 provides the male/female and international distributions.

The American Board of Obstetrics and Gynecology

by Norman F. Gant, MD, Dallas, TX

Exam results

The principal written examination for the American Board of Obstetrics and Gynecology (ABOG) was administered June 30, 2003, at multiple sites.

A total of 1,602 candidates applied for the exam. Of them, 1,165 were new applicants, 1,043 were U. S. medical school graduates (USMGs), 122 were international medical school graduates (IMGs), and 437 were reapplying. Of those individuals reapplying, 327 were USMGs and 110 were IMGs. Pass/fail results are listed in Table 1 on page 32.

The principal oral examination was administered November and December 2003 and January 2004 in Dallas, TX. A total of 1,644 candidates applied for the oral exam: 16 were disapproved ad hoc; 39 were disapproved based on their case lists; 82 turned in incomplete/no-fee applications; two were no-shows; 57 withdrew from the exam; and 1,448 took the exam. Pass/fail rates are listed in Table 2 on page 32.

The number of active diplomates is approximately 33,700.

Exam trends. For U.S. graduates of American medical schools taking the written examination for the first time, the pass rate has ranged from 87 percent to 95 percent. For the entire examination, the pass rate has ranged from 66 percent to

76 percent. The number of applicants for the written examination peaked in the mid-1990s. Since 1997, however, the number of applicants has declined through the year 2003. The major decrease has occurred in reapplicants.

The pass rates for all candidates for the principal oral examination in obstetrics and gynecology have ranged from 83 to 87 percent in the past decade. The number of applicants for the principal oral examination remained constant between 1996 and 1999 (range, 1,650-1,686). The number dropped abruptly by more than 100 to 1,543 in the year 2000, 1,469 in 2001, and to 1,433 in 2002.

Subspecialty exams

The written examinations in reproductive endocrinology/infertility (REI) and maternal-fetal medicine (MFM) were administered June 30, 2003, at multiple sites. Of the 75 people who took the REI exam, 64 passed and 11 failed. Of the 130 people who took the MFM exam, 110 passed and 20 failed.

Subspecialty oral examinations were administered April 7-9, 2003. In the subspecialty of REI, 42 individuals took the oral exam and 28 (67%) passed. A total of 914 physicians currently are board certified in REI to date. In the subspecialty of MFM, 50 individuals took the oral exam and 44 (88%) passed. In the subspecialty of gynecologic

oncology (GO), 48 individuals took the oral exam and 46 (96%) passed. A total of 771 physicians presently are board certified in GO.

Trends/subspecialty written examinations. The number of applicants, those approved to take the examinations and the actual number who took the subspecialty written examinations, in MFM and REI declined in 2001 and 2003. This trend likely reflects the marked decrease in applicants for these fellowship positions first noted three years ago and thought to be due to adding a year to training. The pass rate for the written examination in GO has remained stable since the mid-1990s, between 70 and 82 percent.

A total of 3,186 diplomates have been issued subspecialty certificates (GO, MFM, REI), of whom approximately 2,340 are currently in practice. This number represents approximately 6.9 percent of the total of 33,700 actively practicing diplomates.

Maintenance of certification

Certificate renewal/voluntary recertification written exams were administered June 30, 2003, at multiple sites. Of those physicians seeking to renew their certificates in obstetrics and gynecology (ob-gyn), 116 (97%) passed and three (3%) failed. Of those physicians seeking to renew their certificates in ob-gyn and REI, three passed and one failed.

A total of 7,281 individuals applied for annual board certificate (ABC) renewal and voluntary recertification for 2003 in the areas of ob-gyn, oncology, REI, and MFM. A total of 7,271 were approved, five were disapproved, five withdrew, and 247 were incomplete. Pass/fail numbers and percentages of diplomates who started the ABC process are listed in Table 3 on this page.

Analysis of ABC. For the obstetrics and gynecology portion of the ABC process, several points are noteworthy. The number of applications in 2003 was 6,354. This number has continued to increase yearly since 1999, and almost certainly represents the influx of diplomates with time-limited certificates choosing this method of certification maintenance.

The percentage of diplomates who failed or 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, the number

Table 1

Pass/fail results/written examination

	Passed		Failed	
	#	(%)	#	(%)
Took exam	1,075	(72)	426	(28)
USMGs	990	(76)	319	(24)
IMGs	85	(44)	107	(56)
First-time takers	989	(84)	189	(16)
USMG first-time takers	909	(86)	154	(14)
Reapplications	86	(27)	237	(73)

Table 2

Pass/fail results/oral examination

	Passed		Failed	
	#	(%)	#	(%)
Took exam	1,225	(85)	223	(15)
U.S. graduates	1,165	(85)	200	(15)
International graduates	60	(72)	23	(28)
U.S. graduates— first-time takers	1,065	(87)	156	(13)

Table 3

Pass-fail numbers and percentages of approved diplomates who started the ABC process

	Approved		Passed		Did not complete or failed	
	#	#	(%)	#	(%)	
Ob/Gyn	6,345	6,130	(97)	215	(3)	
ONC	172	160	(93)	12	(7)	
MFM	502	485	(97)	17	(3)	
REI	<u>252</u>	<u>239</u>	<u>(95)</u>	<u>13</u>	<u>(5)</u>	
Totals	7,271	7,014	(96)	257	(4)	

was slightly less than 3 percent and in 2003 the number was 4 percent.

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, and 37 percent in 2003. This trend 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 ABS process in ob-gyn. Approvals of applications have been 100 percent and 98.5 percent in 1999 and 2000 respectively. Approvals were at 99 percent in 2001, 99.5 percent in 2002, and virtually 100 percent in 2003. Since 1999, those individuals failing and/or not completing the subspecialty ABC process appear to have bottomed out at approximately 4 percent. The subspecialists, using the ABC process in ob-gyn, 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, and in 2003, was 33 percent.

Officers and directors

The ABOG officers for the year ending June 30, 2005, are: Philip J. DiSaia, MD, FACS, president; Frank W. Ling, 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 include: Mary C. Ciotti, MD; Larry J. Copeland, MD, FACS; Sherman Elias, MD, FACS; David Gershenson, MD, FACS; Diane M. Hartmann, MD; Nicolette S. Horback, MD; Roy T. Nakayama, MD; Kenneth L. Noller, MD; Valerie M. Parisi, MD; Nanette F. Santoro, MD; Robert S. Schenken, MD; Russell R. Snyder, MD; Michael L. Socol, MD; Ralph K. Tamura, MD; and George D. Wendel, Jr., MD.

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

The American Board of Orthopaedic Surgery

by James H. Beaty, MD, Memphis, TN

Examinations

The American Board of Orthopaedic Surgery (ABOS) administered its Part I written certifying examination in July 2003 to 760 candidates. The overall pass rate was 83 percent. The pass rate for U.S. and Canadian medical school graduates taking the exam for the first time was 93.1 percent, and international medical school graduates taking the test for the first time had a pass rate of 66.7 percent. Repeat examinees had a pass rate of 40.3 percent among U.S. and Canadian candidates, and 26.7 percent for international candidates.

The ABOS offers multiple pathways for recertification in an ongoing effort to improve convenience and make allowances for candidate exami-

nation format preferences and practice profile specificity. The general written recertification examination was administered in March 2003 at the annual meeting of the American Academy of Orthopaedic Surgeons (AAOS) in San Francisco, CA. This was the last "paper and pencil" recertification examination. Ninety-nine percent of the 101 candidates who took the examination passed it.

Of the computerized recertification exam practice profile pathways, 261 candidates took the general examination, of which 256 passed; 52 candidates took the adult reconstructive examination, and all passed; 93 candidates took the sports medicine examination, and all passed; 55 candidates took the spine surgery examination, and all passed;

and 75 candidates took the hand surgery pathway to recertify in surgery of the hand (CAQSH), and all candidates passed. Fifty-six candidates took the oral recertification examination, and 54 candidates passed. Overall, of the 693 candidates taking the recertification examination, 684 (99%) passed.

CAQ hand surgery

The ABOS, in cooperation with the American Board of Surgery (ABS) and the American Board of Plastic Surgery (ABPS) offers a certificate of added qualifications in surgery of the hand. In 2003, a total of 65 candidates took this exam; 50 were ABOS candidates, 13 were ABPS candidates, and two were ABS candidates. This was the first year that all candidates were required to take a

computerized examination. A total of 61 examinees passed the examination, and four failed—two each from the ABPS and the ABS.

A total of 148 candidates took the CAQSH recertification exam—98 ABOS candidates, 28 ABPS candidates, and 22 ABS candidates. One hundred thirty-three candidates passed the exam, and 15 failed for an overall failure rate of 10 percent.

MOC program

A task force composed of representatives of the ABOS and the AAOS is studying the maintenance of certification program. This task force is working diligently to develop a method of assessing performance in practice, which requires a considerable amount of effort by both organizations.

The American Board of Surgery

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

The American Board of Surgery (ABS) met June 13-15, 2004, under the chairmanship of Ronald V. Maier, MD, FACS, beginning with a half-day retreat to discuss issues related to the surgical curriculum. A number of ongoing programs and new initiatives were discussed. They are summarized in this report.

Surgical residency curriculum

The board adopted a position at the January 2004 meeting that a new surgical curriculum needed to be developed for the first three years of residency in order to improve the uniformity, effectiveness, and efficiency of surgical training programs. The board anticipates that more focused teaching of procedural skills early in residency will lead to earlier competence and that use of nonclinical teaching aids will accelerate learning of operative skills and improve operating room technical performance. The ideal would be to have a program of competence-based, rather than time-based, advancement.

Richard H. Bell, Jr., MD, FACS, chair of surgery at Northwestern University, Chicago, IL, and several members of his faculty are develop-

ing a template for such a curriculum, and explained their efforts at the retreat preceding the regular meeting. In addition, the curriculum developed by the thoracic surgery program directors over the last three years appears to be an excellent model for the ABS initiative. Jeffrey P. Gold, MD, FACS, who has spearheaded the thoracic surgery effort, gave a detailed presentation at the retreat.

After extensive discussion, the directors decided that the next step in this effort would be to engage all of the stakeholder organizations in the curricular development, and that the groups should meet to define the scope and timing of the effort. Accordingly, a meeting will be organized to include representatives from the College, the Association of Program Directors in Surgery (APDS), the residency review committee (RRC) for surgery, the Association for Surgical Education (ASE), and the ABS. The board recognizes the College's intention to develop a first-year curriculum that will be applicable to all surgical specialties, and, therefore, plans to mesh its curriculum development effort fully with that of the College.

Postresidency fellowships

The second project that the directors elected to take on in January was the improvement of oversight of postresidency fellowships. Currently, the degree of oversight varies widely, depending upon the fellowship specialty. At one end of the spectrum, the specialties with certificates—such as vascular surgery, pediatric surgery, and surgical critical care—are overseen by the RRC for surgery and accredited by the Accreditation Council on Graduate Medical Education (ACGME), with well-defined program requirements, regular site visits, and relatively stringent oversight. This applies equally to those specialties with independent boards—specifically, thoracic surgery, plastic surgery, and colon and rectal surgery.

Next, there are fellowships that do not have certificates but are accredited by specialty societies with well-defined program requirements or guidelines, such as surgical oncology and transplantation. The remaining fellowships, including trauma, gastrointestinal, laparoscopic, bariatric, endocrine, and others, have limited oversight, guidelines, or program requirements. The board feels that all of these fellowships have the same purpose—to provide further training to general surgeons—and that a greater degree of oversight is needed to ensure the quality of the educational programs and to provide some degree of uniformity in the training provided in a specific discipline. An ad hoc subcommittee of the board has been appointed under the direction of Jeffrey L. Ponsky, MD, FACS, current vice-chair of the board, to begin exploring methods for accomplishing this, principally by working through the various specialty societies.

Maintenance of certification (MOC)

The next major topic of discussion was ongoing development of the MOC program. While many elements of this process will duplicate those of the current recertification program, the review cycle for many of the elements will be shorter than every 10 years, and the need for self-assessment in conjunction with continuing medical education (CME) will be significantly increased. Currently, the board has mandated CME of 50 units yearly, of which 30 units must be Category 1 credits. This requirement will be assessed every three years,

and will also require self-assessment, either in association with the CME or in other independent venues yet to be developed. Ongoing validity of a state or provincial medical license will be determined at three-year intervals as well. The written cognitive examination will continue to be given at 10-year intervals.

Part IV of MOC involves assessment of medical practice, and the board is still working on a final plan for this aspect of the process. The ABMS has asked that practice assessment address all six competencies described by the ACGME and the ABMS, but effective and feasible measures for all of these competencies have not yet been developed. This program will, of necessity, be phased in over the next few years. Outcomes measures would be relevant for most surgeons but are available in relatively few hospitals and specialties, so it will also be some time before we see general availability for all practitioners. The College's current efforts to implement the National Surgical Quality Improvement Program (NSQIP) in university and community hospitals is welcome in this regard, because it may facilitate practice assessment in the future.

Surgeons who recertify in 2005 and thereafter, as well as residents completing surgery residency in June 2005 and thereafter, will be subject to the new MOC requirements, and each year's recertifying cohort will be successively enrolled, so that inclusion of all surgeons will be a 10-year effort.

Computer-based testing

The board adopted computer-based testing in 2003 for specialty recertification, rather than the traditional pencil and paper examination. We contracted with Pearson Vue, a testing vendor with more than 200 testing sites in the U.S., and the transition has gone smoothly. Computer-based testing allows recertifying diplomates to take the examination during a two-week window, rather than on a single day, and to do so at a testing center that is within 50 miles of their homes. This greatly reduces the travel costs and the need to be away from home for more than the day of the test. Our experience in 2003 showed that 85 percent of the diplomates who participated were enthusiastic about the change.

The principal reservations pertained to the security procedures that are required by Pearson Vue for admission to the examination. Examinees are

**American Board of Surgery
Summary of 2003-2004 examinations**

Examination	Number of examinees	# pass	# fail	Pass rate	Failure rate	Total # diplomates
Qualifying	1,268	993	275	78.3%	21.7%	
Recertification	1,489	1,342	147	90.1	9.9	14,528
Vascular surgery QE	118	91	27	77.1	22.9	
Vascular surgery recertification	156	148	8	94.9	5.1	1,277
Surgical critical care	87	77	10	88.5	11.5	2,086
Surgical critical care recertification	125	110	15	88.0	12.0	918
Pediatric surgery QE	57	55	2	96.5	3.5	
Pediatric surgery recertification	94	87	7	92.6	7.4	550
Hand surgery	2	2	0	100	0	226
Hand surgery recertification	22	17	5	77.3	22.7	92
Pediatric surgery ITE	72	—	—	N/A	N/A	
IT/SBSE	7,471	—	—	N/A	N/A	
Certifying	1,216	1,019	197	16.2	16.2	4,9374
Vascular surgery CE	121	106	15	83.8	12.4	2,365
Pediatric surgery CE	64	57	7	89.1	10.9	934
Total	12,434					

N/A =Not applicable.

4,891 examinees, excluding the IT/SBSE and PITE.

prohibited from bringing any material or personal effects into the testing room, and must check all personal items—including wallets, cell phones, and watches—in lockers prior to entering. While the ABS did not mandate these security procedures, Pearson Vue applies them to all test takers at their centers, and other clients of the firm require that the procedures be met, so we are unable to modify them for surgeons.

In September and October 2004, general surgeons made the transition to computer-based recertification examinations, in addition to the surgical specialists who transitioned last year. In 2005, the final change will be made in written examinations, and the qualifying examinations for general surgeons as well as specialists will be given in Pearson Vue centers. At that point the board will be entirely out of the pencil and paper testing mode.

Change in examination dates

A further major change will be made in 2005 in the examination dates of both the qualifying examination (QE) and the recertification examination in surgery. The QE will be advanced by two months to make it more proximate to the conclusion of residency and will be given in early August, rather than the usual October date. This change will reduce the distraction of the QE for residents in fellowship training after general surgery residency, which has been a problem for some time, and will also allow successful residents to move ahead to the oral examinations immediately in the fall, rather than delaying this step until the next year. Therefore, it will be possible for at least half of the graduating residents to complete the certification process before the end of the year in which they graduate from residency.

The other change in 2005 dates is for the recertification examination in surgery, which will be moved back approximately two months to early December. The specialty qualifying examinations, as well as the specialty recertifying examinations, will still be given in October, but general surgery will be two months later.

Primary vascular surgery certificate

The last major activity of the past year has been the filing of an application with the ABMS for issuance of a primary certificate in vascular surgery by the ABS. This effort was approved by the directors at the January meeting after extensive meetings with the Society for Vascular Surgery and the Association of Program Directors in Vascular Surgery (APDVS). The rapid expansion of endovascular therapies has fundamentally changed the nature of vascular surgery practice, and significantly decreased the amount of intraabdominal surgery that is being done. (Presently, more than 50% of abdominal aortic aneurysms are repaired with endovascular techniques, and, at some institutions, it is up to 80%.) As a result, prior full training in general surgery with certification is no longer felt to be essential, while there is a need for expansion in the amount of vascular training.

Under ABMS bylaws, a subspecialty certificate cannot be issued without the diplomate holding a prior primary certificate. To accommodate a change in the vascular curriculum, the only route available is to create a primary certificate in vascular surgery, parallel to the present certificate in surgery. There is ample precedent for this, as four other boards currently issue multiple primary certificates, so after the approval of the directors in January an application was filed with the ABMS to allow the ABS to issue the new certificate. The approval process is lengthy, and requires a minimum review period of one year. If other boards oppose the new certificate, the process could be lengthened.

Currently the American Board of Radiology has registered its opposition to the primary vascular certificate, and the first hearing on the issues will occur September 22 at the interim ABMS meeting.

ABS/ABTS joint training program

The other action that is going before the ABMS in September is a joint training proposal developed by the American Board of Thoracic Surgery (ABTS)

and the ABS, which provides for development of a joint program in a single institution by which a resident could qualify for both certificates in a total of seven years of training. The program will continue to require completion of all the same program requirements currently mandated by each board, but will allow greater degrees of overlap in rotations during the fourth and fifth residency years, and will allow some rotations to count for credit in both specialties. This application will be reviewed by the ABMS in September and, if approved, will go to the RRCs of surgery and thoracic surgery for the development of specific implementation guidelines.

New and retiring directors

New members elected to the American Board of Surgery are: Stanley W. Ashley, MD, FACS, from the Association for Academic Surgery; Jeffrey B. Matthews, MD, FACS, from the Society of University Surgeons; John J. Ricotta, MD, FACS, from the Association of Program Directors in Vascular Surgery; William P. Schecter, MD, FACS, from the Pacific Coast Surgical Association; and Ronald J. Weigel, MD, FACS, from the Society for Surgical Oncology.

Directors who are completing their six-year term and leaving the board after June 30 are: Ronald V. Maier, MD, FACS, chair; Julie A. Freischlag, MD, FACS; Timothy J. Eberlein, MD, FACS; Frank W. LoGerfo, MD, FACS; and Bruce E. Stabile, MD, FACS. All of these individuals have provided outstanding service to the board for the last six years, and all directors expressed their gratitude to them.

New officers

Barbara L. Bass, MD, FACS, assumed the chair of the board at the end of the June meeting for the 2004-2005 year. Vice-chair is Jeffrey L. Ponsky, MD, FACS, of the Cleveland Clinic. Subsequently, the directors have chosen the new vice-chair-elect, and we are pleased to announce that Courtney Townsend, MD, FACS, chair of the department of surgery at the University of Texas, Galveston, has been elected.

Staff member retires

George Cruft, MD, FACS, retired from the staff of the ABS June 30 after serving for 30 years. Dr. Cruft has had two completely independent careers, the first half in multiple positions of senior re-

sponsibility at naval hospitals, and the second at the American Board of Surgery, where he has made major contributions to the procedures of the board and the rigor of the examinations it administers. He has provided invaluable service to four different executive directors, and his encyclopedic knowledge of board operations, as well as

his unfailingly excellent judgment, will be sorely missed.

Necrology

It is with great regret that we report the deaths of Richard L. Varco, MD, FACS, on May 2, 2004, and John D. Ashmore, Jr., MD, FACS, on May 9, 2004.

The American Board of Thoracic Surgery

by Timothy J. Gardner, MD, FACS, Newark, DE

Inactive status

Diplomates holding a valid certificate from the American Board of Thoracic Surgery (ABTS) who anticipate being clinically inactive for one year or more may apply for inactive status. Applications must be submitted in writing and approved by the board before inactive status will be granted. Activities calling for such status include, but are not limited to, academic sabbaticals, advanced studies, elected/appointed political offices, temporary disability due to illness, or appointment to administrative positions in hospitals, medical schools, or health care-related industries. For more information about 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 toward implementing 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 believes 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. This change allows diplomates to include continuing medical education (CME) hours earned at meetings held in the spring. Additionally, diplomates must be in compliance with the annual certification maintenance fee in order to enter the recertification process. Additional information concerning the recertification requirements can be found in the annual *Recertification Booklet of Information*.

In 2003, 236 diplomates recertified, of which 134 did so for the first time and 102 for the second time. One hundred ninety diplomates used the SESATS computer version, and 46 diplomates used the paper-and-pencil version. (See table on page 39 for more information.)

Background

Diplomates certified after 1975 must recertify within 10 years of the date of the original certification 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 American Board of Thoracic Surgery 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 to defray administrative and computer expenses. The board will not re-

ABTS recertification activity (current through 2003)

<u>Date of original cert.</u>	<u>Total # cert.</u>	<u>Total # recert. first time</u>	<u>Percent recert.</u>	<u>Total # recert. second time</u>	<u>Percent recert. second time</u>
Prior to 1976	N/A	67	—	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	108	79
1984	135	125	93	76	56
1985	120	119	99	36	30
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	131	93	—	—
1994	156	109	70	—	—
1995	159	47	30	—	—

spond to inquiries about the diplomate's certification status until the annual fee is paid.

Examinations

For the first time, the ABTS administered the Part I (written) exam in a computer-based format December 6, 2004, at Pearson Professional Testing Centers, throughout the nation. By offering the exam in a computer-based format, the board anticipates that most candidates will be able to take the exam at a site located near their homes. The ABTS would like to thank the American Board of Surgery, in particular Robert S. Rhodes, MD, FACS, associate executive director, who has facilitated the board's relationship with Pearson.

On November 23, 2003, the board administered its eleventh criterion-referenced Part I (written) exam to 164 individuals. The pass rate for the examination was 89 percent. The board administered its eighth criterion-referenced Part II (oral) exami-

nation to 165 individuals June 11-12, 2004. The pass rate for the examination was 91 percent.

New pathways/requirements certification

Certification by the ABTS may be achieved by completing one of the following two pathways and fulfillment of the other requirements outlined in the board's *Booklet of Information*:

1. Successful completion of a full general surgery residency approved by the ACGME (five years) or the Royal College of Physicians and Surgeons of Canada, followed by the successful completion of a two- or three-year ACGME-approved thoracic surgery residency. Certification by the American Board of Surgery (ABS) is optional for individuals who started their thoracic surgery residencies in July 2003 or after.

2. Successful completion of a categorical-integrated six-year thoracic surgery residency, to be developed by the Thoracic Surgery Directors

Association. 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 must first approve institutions to offer such programs. As of this report, no institution has received accreditation for a categorical-integrated thoracic surgery residency.

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

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 applying 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.

In-training examination

The 2004 in-training exam was administered online March 27 and April 3 to 354 residents and fellows. The in-training examination consists of general thoracic and cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination.

College representation

Both of the College's representatives to the Board of Thoracic Surgery will complete their terms of service as directors this year. Gordon N. Olinger, MD, FACS, has been a director since 1994. His original six-year term was extended when he was elected examination chair, a position he has held since 2001. David B. Campbell, MD, FACS, has served as board director since 1996. His term also was extended because of his key role in developing the electronic format for the board's qualifying examination, which was

initiated at multiple computer testing centers in the U.S. for the first time in December 2004.

Drs. Olinger and Campbell both have had important leadership responsibilities with the board and have been instrumental in advancing the board's efforts at examination revision and modernization. Dr. Olinger, who has been a board representative to the ABMS, where he served as chair of the COCERT, also has led the board's efforts in initiating a maintenance of certification program.

At the Board of Thoracic Surgeons meeting in Florida October 21-23, 2004, new College representatives were elected to director positions to replace Drs. Olinger and Campbell. The Advisory Council for Cardiothoracic Surgery nominated two slates of candidates for the College seats on the board, and these nominees, who were approved by the Board of Regents, were considered for election at the board meeting October 24. David M. Harpole, Jr., MD, FACS, Durham, NC, and Edward L. Bove, MD, FACS, Ann Arbor, MI, were elected as the new board directors representing the College. □