

Ten specialty boards report accomplishments and plans:

Part I

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 Plastic Surgery, and the American Board of Urology.

The April issue of the *Bulletin* will feature reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Surgery, and the American Board of Thoracic Surgery.

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 25, 2005, and its most recent interim meeting March 20, 2005, in Chicago, IL, at the Omni Hotel. Future meetings will take place at the same site through 2008. The schedule is as follows:

Written examination/interim meeting: March 25–26, 2006, March 17–18, 2007, and March 19–30, 2008.

Oral examination/annual meeting: September 29–October 1, 2006, September 28–30, 2007, and September 19–21, 2008.

Officers/members of the board

The Board is now composed of 15 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 nominates four, the American College of Surgeons nominates two, the Association of Program Directors for Colon and Rectal Surgery nominates two, and the American Board of Surgery nominates one. The ad hoc associate executive director is a board nominee who serves in a transitory capacity (without vote) and only in anticipation of the retirement of the executive director. Board members normally serve two four-year terms.

Herand Abcarian, MD, FACS, officially announced his plan to retire, as of September 2006, as the board's secretary-treasurer/executive director, a position he has held since 1986. His successor, David J. Schoetz, Jr., MD, was formally elected at the March 20 interim meeting. Dr. Schoetz's capabilities are well known through his past board service, his involvement with the society, and his numerous contributions to the specialty.

Board officers are Vendie H. Hooks, MD, FACS, president, and Richard P. Billingham, MD, FACS, vice-president.

Current board members are: E. Christopher Ellison, MD, FACS; Terry C. Hicks, MD, FACS; Martin A. Luchtefeld, MD, FACS; Robert D. Madoff,

MD, FACS; Patricia L. Roberts, MD, FACS; John P. Roe, MD, FACS; Clifford L. Simmang, MD, FACS; Michael J. Stamos, MD, FACS; Steven D. Wexner, MD, FACS; Bruce G. Wolff, MD, FACS; and W. Douglas Wong, MD, FACS.

Membership matters

At its March 20, 2005, interim meeting, the board approved bylaws changes that affect the composition of sponsoring organizations and members. The first change affects Article IV, Election and Duties of Officers. It provides for the appointment of an ad hoc associate executive director who will serve in a transitional capacity when the executive director decides to retire. This change also established a mechanism that will give board members input into the selection process. Dr. Schoetz is the board's first ad hoc associate executive director.

The second change refers to Article III, Section 1, Membership, which affects board membership and sponsorship. This will eliminate the American Medical Association (AMA) as a sponsoring organization of the board. Board members agreed that the AMA no longer has close ties to the ABCRS and should not serve as a nominating body. The AMA slot will be given to the ABCRS, increasing its sponsorship to four members instead of three. At the October 3, 2004, annual meeting, Steven Wexner, MD, FACS, an AMA nominee, was elected to the board and will be the last AMA representative. A provision was made to allow Dr. Wexner to serve a complete eight-year term.

Examination committee activities

The board's examination committee is divided into three working groups consisting of the written, oral, and maintenance of certification (MOC) subcommittees; each is directed by its own chairperson. At the September 25, 2005, meeting, Dr. Wolff officially became the new examination committee chair and Dr. Roberts the written examination committee chair. Dr. Hicks

continues to serve as the oral examination chair and Dr. Hooks as the maintenance of certification chair.

Oral examination. The ABCRS oral examination committee continues to focus on standardizing the oral examination process. The ultimate goal is to build the oral examination pool with quality case scenarios. Dr. Hicks believes testing candidates on the same material has made the oral examination more objective and provides a method that better identifies the areas in which candidates fail.

Following the annual board meeting in October 2004, the following changes or refinements were made to the oral examination process:

- Written summaries replaced oral critiques.
- Candidate surveys were conducted.
- E-mail notification of oral examination results was approved.

Written examination. In addition to the four-hour written examination, a visual diagnostic exam is given to candidates. This component combines elements of radiology and pathology into 40 questions incorporating gross and endoscopic photos, various diagnostic studies, and histology. Overall, it covers the gamut of colon and rectal surgery ailments. Formerly, separate X-ray and pathology examinations (consisting of 25 questions each) were given, but the board believes that combining the two components has made that portion of the examination more relevant to the specialty. The images and corresponding cases more closely resemble “real life” scenarios and authentic practice settings germane to colon and rectal surgery.

The written examination committee is considering ways to improve the written exam. It has been suggested that in the future the separate visual diagnostic examination could be incorporated into the written examination. With current technology, photographs could easily be introduced into the exam. In addition, the committee has considered whether there is a better way to conduct future examinations more efficiently, more economically, and more effectively. For example, one approach would combine the written and oral examinations. Also, there have been discussions regarding use of a central examination facility that would enable the board to conduct

computerized examinations. These and other ideas will continue to be explored.

Recertification examination. The last recertification examination was given April 29–30, 2005, in Philadelphia, PA. A total of 66 diplomates participated; 65 passed (98%) and one failed (2%). The next recertification examination will be given June 3, 2006, in Seattle, WA.

The recertification statistical summaries for the last 15 years are provided in Table 1 (see page 32).

Transition to MOC

The recertification committee was officially renamed the MOC committee in 2003, and over the past two years, the ABCRS has been working to develop MOC components.

The MOC process for colon and rectal surgery—for which each activity occurs every five years unless otherwise specified—is composed of the following four components:

- *Professional standing*
 - Full, unrestricted license to practice medicine in all jurisdictions in which the diplomate practices
 - Hospital privileges to practice colon and rectal surgery (every five years)
 - Recommendations from the chief of staff of the primary hospital
- *Lifelong learning and self-assessment*
 - 150 hours of Category 1 CME credit
 - Colon and Rectal Surgical Education Program
- *Cognitive knowledge*
 - MOC cognitive examinations—taken during the eighth, ninth, or tenth year of the MOC process (every 10 years)
- *Assessment of practice performance*
 - Patient survey: 15 questions from 20 patients
 - Operative log consisting of cases performed six months before the end of the five-year cycle

Assessment of practice performance is the most challenging because it requires boards to establish a process for assessing physician practice performance. The purpose of the assessment is to demonstrate to patients, the public, and the profession that physicians provide safe, effective, and patient-centered health care. At the MOC

committee's recent meeting, discussion continued as to what components will be required in the ABCRS Part IV MOC process. In addition, modifications were made to the already approved

Parts I through III. Completion of Part IV is nearly final, and the board's goal is to submit the draft to the American Board of Medical Specialties by March 2006.

Table 1: ABCRS recertification performance, 1991-2005

Year	Participants	Passed	%	Failed	%	Maximum (%)	Minimum (%)	Average (%)
2005	66	65	98	1	2	94	68	88
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
1991	7	7	100	0	0	97	91	94
Totals	417	388	95	29	5	94	72	85
						Passing score 70%		

Table 2: Examination results: Pass/fail rates

Written exam - March 19, 2005 (71 candidates)						Oral exam - September 24, 2005 (71 candidates)				
	#	Fail rates	%	Pass rates	%	#	Fail rates	%	Pass rates	%
Total candidates	71	11/71	15	60/71	85	71	10/71	14	61/71	86
First-time takers	61	8/61	13	53/61	87	62	5/62	8	57/62	92
Repeat candidates	10	3/10	30	7/10	70	9	5/9	56	4/9	44

Table 3: Geographic/gender distribution

Status	Male	%	Female	%	All	%
Active U.S.	1,137	72.65	141	9.01	1,278	81.66
Active international	63	4.19	5	0.33	68	4.52
Retired U.S./inactive	194	12.90	4	0.27	198	13.16
Retired international	5	0.33	0	0.00	5	0.33
Status/address unknown	6	0.40	0	0.00	6	0.40
Inactive/expired certificate holders	9	0.60	1	0.07	10	0.66
Total	1,414	90.35	151	9.65	1,565	100.00

Electronic operating log

An ad hoc committee headed by Robert Madoff, MD, FACS, has worked to develop an electronic operative log reporting system as a joint effort between the American Council of Graduate Medical Education (ACGME) and the ABCRS. The effort has progressed to the final stage. The plan will use preexisting ACGME Web-based software, which will be accessible to all colorectal residents. The ABCRS administrative office will also have access but will have to adapt it to suit its particular software and reporting needs. The procedure-based program concept is to have each procedure requiring documentation of diagnosis through the use of a drop-down menu. Thereafter, the collected data can generate reports geared to the specific needs of the ABCRS, the RRC, and the ACGME. At the March 20, 2005, interim meeting, Dr. Madoff briefly reviewed the program. He reported that the case log system is now being used by 26 specialties. In 2004, residents logged 6.5 million cases. The basic concept is the same for all specialties, but each specialty has its own unique features. The board decided to make the electronic process mandatory for all residents entering colon and rectal training programs beginning July 1, 2005, and completing by June 30, 2006.

Continuing toward the goal of electronic accessibility and exchange of information, the board certification application is now available online. The application can be accessed through the ABCRS Web site (www.abcrs.org) by clicking

“On-line Application” on the sidebar. The procedure is user friendly and will help to expedite the application process. The MOC application will be available online in the near future. On a broader scale, the board’s objective is to develop a centralized software solution for the central office. The goal is to create a more efficient method to track surgeons through various stages of the certification process and to eliminate the need to copy data from one database to another. The plan will include reprogramming the current operative database so it is compatible with the new Web-based ACGME system. A reporting mechanism will be designed to incorporate the board’s category system and automate the process of preparing various reports.

Examination results

The most recent written examination (Part I) was given March 19, 2005; 71 candidates were examined. The most recent oral examination (Part II) was given September 24, 2005; 71 candidates were examined. The pass/fail rates are shown in Table 2 on page 32.

Geographic/gender distribution

As of October 2005, the board has a total of 1,565 diplomates: 1,346 are in active practice, 203 are retired, six of unknown address or status, and 10 have expired certificates. Table 3 on this page shows the distribution of male, female, and international diplomates.

The American Board of Obstetrics and Gynecology

by Norman F. Gant, MD, Dallas, TX

Officers and directors

Officers of the American Board of Obstetrics and Gynecology (ABOG) are Philip J. DiSaia, MD, FACS, Orange, CA, president; Gerson Weiss, MD, Newark, NJ, chairman of the board; Mary C. Ciotti, MD, Sacramento, CA, vice-president; Larry C. Gilstrap III, MD, Houston, TX, treasurer; William Droegemueller, MD, Chapel Hill, NC, director of evaluation; and Norman F. Gant, MD, Dallas, TX, executive director. Directors include Bruce R. Carr, MD, Dallas, TX; Larry J. Copeland, MD, FACS, Columbus, OH; Sherman Elias, MD, FACS, Chicago, IL; Diane M. Hartmann, MD, Rochester, NY; Nicolette S. Horbach, MD, Annandale, VA; Frank W. Ling, MD, Memphis, TN; Roy T. Nakayama, MD, Honolulu, HI; Valerie M. Parisi, MD, MPH, Galveston, TX; Stephen C. Rubin, MD, FACS, Philadelphia, PA; Nanette F. Santoro, MD, Bronx, NY; Robert S. Schenken, MD, San Antonio, TX; Russell R. Snyder, MD, Galveston, TX; Michael L. Socol, MD, Chicago, IL; Ralph K. Tamura, MD, Chicago, IL; and George D. Wendel, Jr., MD, Dallas, TX.

Programs and fellowships

The ABOG and the American Board of Urology continue to work jointly to insure the success of the combined Female-Pelvic Medicine and Reconstructive Surgery Fellowships. At press time, there are 22 accredited fellowship programs in this new subspecialty; among these programs, 21 are obstetrics and gynecology programs and one is a urology-sponsored program.

The board now has received applications from five additional urology programs, which are being site visited this fall. It appears this effort will be successful with both boards working together to ensure that with the increasing age of our population, women with these disorders can be managed medically as well as surgically.

Maintenance of certification

The ABOG continues to work in close association with the American College of Obstetricians

and Gynecologists to complete Part IV of our maintenance of certification requirements for the American Board of Medical Specialties (ABMS). The first three parts of maintenance of certification for the ABOG have been approved through the first and second readings at the ABMS. These programs include professionalism, lifelong learning, and cognitive expertise.

What remains is the final approval of the board and College's joint efforts to develop an acceptable program for Part IV, which will be for continuous quality improvement until methods are developed to assess a practitioner's quality of clinical care.

New foundation started

The Foundation for Excellence in Women's Health Care has been started by the ABOG. The first project will be a lifelong learning project for all residents in obstetrics and gynecology in the U.S.

The goals of the lifelong learning program are twofold: to assist program directors in habituating residents to the discipline of lifelong learning and in providing documentation of effective instruction in cognitive knowledge during a residency review committee site visit.

The foundation proposes to send a new package to each residency program director with different references approximately every two months. Each package will contain one book for the program director with a keyed answer sheet and one book and answer sheet for each resident. Each book will have six references: two in gynecology, two in obstetrics, and two in office practice. There will be 30 multiple choice questions composed of 10 questions from the two references in each of the three sections.

The keyed answers provided to the program directors will be derived from the references, but they are not intended to provide definitive clinical advice or instruction. The program directors will have the prerogative of modifying, correcting, or rejecting any suggested answer

in reviewing the questions with residents. The board does not request that the residents' answer sheets be returned to the ABOG. Program directors may also see fit not to use the answer sheet at all or may restructure it, in whole or in part, to meet specific training and teaching needs.

Happy anniversary

On November 5, the ABOG will celebrate its 75th anniversary. The ABOG was founded in 1930 as the third specialty board, preceded by the boards of ophthalmology and otolaryngology. It should also be noted that the ABOG was a founding member of the ABMS.

The American Board of Orthopaedic Surgery

by Peter J. Stern, MD, FACS, Cincinnati, OH

The purpose of the American Board of Orthopaedic Surgery (ABOS) is to serve and protect the public and the medical profession by testing and setting minimal educational standards for those individuals who after successful completion of an accredited residency seek certification in orthopaedic surgery.

Primary certification

Primary certification begins with a written, seven-hour examination to evaluate fund of knowledge and is taken annually in July, just following completion of residency. In 2004, it was administered to 645 individuals, and the passing rate overall was 88 percent. Approximately two years after the written exam, an oral examination is administered. Candidates electronically submit six-month case lists from which 12 cases are selected. Each candidate is evaluated by six examiners who assess nine clinical and surgical skills. Failure rates since 1986 have varied between 8 percent and 15 percent.

Recertification

Since 1986, certificates issued are time limited. To ensure this end, every 10 years, ABOS diplomates must *recertify*. The ABOS reviews the credentials and practices of volunteer candidates, verifies a commitment to lifelong learning (continuing medical education, or CME). In addition, a secure practice profile-based exam or an oral exam is administered to assure the public and profession of diplomates' continuing qualifications and competence.

Maintenance of certification

Because of external regulatory pressure and public demand, the American Board of Medical Specialties (ABMS), the umbrella organization to which all 24 medical specialty boards belong, believes that its member boards should have a leadership role in improving quality of care through a process termed maintenance of certification (MOC). For the past several years, the ABOS has spent considerable time preparing for the transition from recertification to MOC.

The four components of MOC approved by the ABMS are evidence of professional standing (licensure and peer review), lifelong learning and self-assessment, evidence of cognitive expertise (examination), and evidence of performance in practice.

The first component, evidence of professional standing, is already in place for ABOS. Lifelong learning and self-assessment will be accomplished by diplomates completing two three-year cycles of 120 hours of Category 1 CME credits and two self-assessment exams.

Since the inception of the time-limited certificate, successful passage of a secure recertification examination has been required to demonstrate that the candidate has a sufficient knowledge base to continue to practice orthopaedic surgery. To this end, the ABOS has constructed multiple computer-based, practice-profile examinations to assess a diplomate's knowledge base. Last year, 98.4 percent of those taking one of these examinations passed. If one prefers, he or she may be examined by an oral

pathway, which is similar to initial certification in which preselected cases from the examinee's practice are presented. The passage rate using this pathway was 89 percent in 2004. Finally, the ABOS is deciding on the best methods to assess the fourth component of MOC, performance in practice. A joint task force of members from the ABOS and the American Academy of Orthopaedic Surgeons has suggested practice performance assessment by the following methods: Peer review, patient questionnaire assessing physician communication skills and patient satisfaction, and a three-month list to assess best practices. Currently, the task force is developing criteria for best practices including performance measures

The first date for transition from recertification to MOC will be for those diplomates whose certificates expire in 2010.

Other developments

Subspecialty certification has been available in hand surgery since 1989. In 2007, a second

subspecialty certificate in sports medicine will be available.

Last fall, the board selected two directors-elect, James R. Kasser, MD, from Boston, MA, and Daniel J. Berry, MD, from Rochester, MN. In keeping with its commitment to serve the best interests of the public, the board appointed its first public member, E. Thomas Sullivan, JD, senior vice-president and provost at the University of Minnesota.

Finally, the mission of the ABOS could not be accomplished without the more than 200 physician volunteers and the capable oversight of its executive director, G. Paul DeRosa, and his tireless staff. Transitioning from recertification to MOC has been the board's major initiative over the past three years. Our academy has been most supportive and has been particularly helpful in the domains of assessment of practice performance and commitment to lifelong learning. Ultimately, our patients and the profession we serve will benefit from our insistence of maintenance of high standards so necessary in these changing times.

The American Board of Plastic Surgery

by John A. Persing, MD, FACS, New Haven, CT

Examinations

Oral examination: A total of 209 candidates sat for the oral examination November 11-13, 2004, in Phoenix, AZ. Among those candidates, 169 successfully completed the certification examination and 40 failed, with a failure rate of 19.1 percent. In November 2003, 206 candidates took the oral examination; 173 candidates passed and 33 (16%) failed. The usual failure rate range has been 16 to 25 percent. There were 203 candidates for the 2005 oral examination. As of November 13, 2004, the ABPS had certified 6,841 plastic surgeons.

Written or qualifying examination: The computer-based test (CBT) written or qualifying examination was held October 18, 2004, for 214 candidates. Results of the 2004 written examination were distributed December 22, 2004: 178 of

the total of 214 candidates successfully completed the written examination, with a failure rate of 23 percent. In 2003, 177 of 230 candidates passed the written examination, with a failure rate of 23 percent, which was consistent with previous years. The 2005 examinations were offered for the fourth time as a CBT and were held October 18, 2005, at test centers across the country. A total of 237 candidates sat for the 2005 written examination.

Subspecialty certification in surgery of the hand: ABPS administered the 2004 subspecialty certification in surgery of the hand (formerly known as the certificate of added qualifications in surgery of the hand) examination to 62 American Board of Plastic Surgery (ABPS) diplomates, 44 of whom were recertifying. Among 18 diplomates, 15 passed the hand surgery examination. The

total failure rate for all 15 examinees was 16.7 percent. A total of 44 diplomates sat for the 2004 hand surgery recertification examination; 35 passed, and 9 (20.5%) failed. The 2005 certification examination in surgery of the hand was administered as a CBT from August 6 through September 3, 2005.

Recertification/maintenance of certification: The third recertification examination was administered April 2005. In 2004, 159 took the examination and 151 passed; eight (95%) failed. Sixty-six candidates sat for the comprehensive surgery module, 82 examinees sat for the cosmetic surgery module, four candidates sat for the craniomaxillofacial module, and seven candidates sat for the hand surgery module. Among these candidates, two were lifetime certificate holders. In 2003, 122 diplomates took the examination and 118 (96.7%) passed and four failed. Among these diplomats, nine were lifetime certificate holders.

The cognitive examination continues to be offered as a CBT in four modules: Comprehensive plastic surgery, cosmetic/breast surgery, craniomaxillofacial surgery, and hand surgery. A subspecialty certificate in surgery of the hand was accepted in lieu of the hand surgery module cognitive examination component of the recertification program. The four key components of professionalism, knowledge, lifelong learning, and performance in practice are incorporated into the recertification program. Diplomates are required to collect an operative log for six months for assignment to an examination module in the areas of their practice profile. Maintenance of certification for plastic surgery is planned to start in 2007.

Evaluation of prerequisite training years: A task force for the evaluation of training pathways is currently evaluating the duration and content of the prerequisite years in training. A tripartite retreat was held in Chicago in September 2005—representatives from the Residency Review Committee for Plastic Surgery, the Academic Chairmen in Plastic Surgery, and the board reviewed the issues in depth.

Revocation of certification

The board is using the Federation of State Medical Boards Disciplinary Alert Notification

System through the American Board of Medical Specialties to identify diplomates with state medical license sanctions. Plastic surgeons with revoked state medical licenses are referred to the ethics committee for revocation of certification. To date, the board has revoked certification for 44 diplomates. This information was also published in the board's annual newsletter to diplomates in January 2005.

ABPS code of ethics

The board's code of ethics continues to attract reporting and enforcing issues regarding advertising and expert witness testimony. Most recently, the ABPS code of ethics prohibition to participation in contests has drawn attention because of the proliferation of reality television programming. In January 2005, the board published a position statement on reality television in the annual newsletter. The board requires all examiners and directors to sign a statement attesting that they have not participated in reality television programming.

Subspecialty issues

The ABPS continues to be committed to the engagement, development, and recognition of subspecialty interests for the purpose of advancing the core of the entire specialty. The board's four advisory councils have been working since May 2000 on contributing to the work of the recertification process and maintenance of certification program. The advisory councils reflect the four identified subspecialty modules for the recertification program. The members include board directors and nominees from plastic surgery subspecialty organizations. The board currently uses subspecialty expertise to develop journal review questions for self-learning for the *Plastic and Reconstructive Surgery Journal*.

In appreciation

At the May board meeting, the ABPS honored the following directors and expressed appreciation for their work: Lawrence L. Ketch, MD, director, 1998-2005, chair, 2004-2005; Gustavo A. Colon, MD, FACS, director, 1999-2005; Dennis J. Lynch, MD, FACS, director, 1999-2005; and Peter W. McKinney, MD, FACS, director, 1999-2005.

New officers and directors

The new directors elected to the ABPS on May 7, 2005, are: Gregory R. D. Evans, MD, Orange, CA; Bahman Guyuron, MD, Lyndhurst, OH; and Donald H. Lalonde, MD, Saint John, NB.

ABPS Officers for 2005-2006 are: John A. Persing, MD, FACS, chair; Thomas R. Stevenson, MD, FACS, chair-elect; Linda G. Phillips, MD, FACS, vice-chair; and Ronald E. Iverson, MD, FACS, secretary-treasurer.

The American Board of Urology

by Robert C. Flanigan, MD, FACS, Maywood, IL

Exams

The certification process of the American Board of Urology incorporates a qualifying examination (Part 1) and a subsequent certifying examination (Part 2). Admissibility to the qualifying examination requires that the applicants have completed or be within six months of satisfactorily completing an Accreditation Council on Graduate Medical Education (ACGME)-approved urology residency program. Admissibility to the certifying examination requires that the candidates have passed the qualifying examination, have 18 months of clinical practice experience in a single community, submit an acceptable practice log, and receive satisfactory peer reviews.

On August 6, 2004, 317 candidates completed the qualifying examination. In 2004, the examination was administered for the first time as a computer-based test. The exam was a cognitive, multiple-choice examination. The computer-based testing allows candidates to enter their responses directly into the computer and to view enhanced images on the screen. Of 317 candidates who sat for the qualifying examination, 263 passed and 54 failed. As has been true in other years, practitioners—educated in the U.S. or abroad—who have previously failed the examination had a high rate of re-examination failure. The 2005 qualifying examination took place August 5, 2005. A total of 299 candidates took the 2005 examination.

Since 1987, the qualifying examination has been scored using the principles of criterion-referenced testing, whereby the pass level is equated to a previous benchmark test using the Rasch model. The passing score will vary accord-

ing to the difficulty of the examination for any year. Thus, although an examination may vary in difficulty from year to year, the probability of passing (pass rate) is based solely on the ability of the candidate pool in any given year. This is a fair and defensible methodology, which does not impose an arbitrary pass/fail point.

The 2005 certifying examination was a standardized oral examination that consisted of six protocols on which the candidate was tested. In February 2005, 262 candidates took the certifying examination; 249 (95%) passed and were certified, and 13 (5%) failed. The board uses a modified Rasch model for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. Consistent with the board's commitment to continually improving its evaluation processes, in 1995 the board applied a dual-scoring system for the oral examination protocols. Separate grades are used for information gathering and diagnosis and for problem solving and patient management. This has resulted in a significant increase in statistical reliability. The board is pleased with this scoring technique for the oral examination.

Certification

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

In 1992, the board began its mandatory recertification process for all diplomates with 10-year, time-limited certificates, which have been issued since 1985. Currently, all trustees of the American Board of Urology recertify during their tenure on the board unless, because they were originally certified after 1985, they have already recertified to retain their certification. The process consists of multiple components. These various components provide the diplomate with different opportunities and ways to document his or her competence. A secure, computer-based, closed-book examination consists of five subject areas; the diplomate chooses the three subject areas with which he or she is most comfortable. Each module has 30 questions, for an individual examination of 90 questions.

Other components of recertification include peer review, a practice log review, and a continuing medical education requirement. In addition, at the board's discretion, hospital/office chart reviews, an oral interview or examination, and/or a site visit may be required. Diplomates may enter the recertification process up to three years before expiration of the primary certificate. Upon successful recertification, the diplomate is issued a certificate valid for 10 years from the date of expiration of the original certificate. The 2002 recertification process was the first year that included diplomates recertifying for their second time. In November 2004, the last year for which this information was available at press time, 483 diplomates sat for recertification; 466 diplomates (96%) successfully completed the recertification process. The pass rate was consistent with that of previous years.

All of the boards with the American Board of Medical Specialties are developing a maintenance of certification (MOC) process that would supersede their existing recertification processes. The MOC will entail, among other things, ongoing monitoring of physicians by the certifying boards. The American Board of Urology is actively developing a MOC model. Currently the board is planning to implement MOC in 2006 or 2007. More information on the details of the MOC process will be widely disseminated to all candidates, diplomates, and societies when the process is in its final form and approved by the board and the American Board of Medical Specialties.

Officers and trustees

Current officers and trustees are: Robert C. Flanigan, MD, FACS, president; Mani Menon, MD, FACS, vice-president; Linda M. Shortliffe, MD, FACS, president-elect; Peter R. Carroll, MD, FACS, secretary-treasurer; Peter C. Albertsen, MD, FACS; David A. Bloom, MD, FACS; Ralph V. Clayman, MD, FACS; Michael O. Koch, MD, FACS; Paul H. Lange, MD, FACS; Howard M. Snyder III, MD, FACS; William D. Steers, MD, FACS; and W. Bedford Waters, MD, FACS. 