

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 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 March issue of the *Bulletin* featured 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 American Board of Neurological Surgery

by William F. Chandler, MD, FACS, Ann Arbor, MI

Resident numbers, neurosurgical match

During the 2004-2005 academic year, there were 94 neurosurgical residency training programs accredited by the residency review committee (RRC) for neurological surgery under the Accreditation Council for Graduate Medical Education (ACGME) in the U.S. As of June 2005, 851 residents were in training and 139 had graduated.

In January 2005, 346 individuals registered for the Neurological Surgery Matching Program. There was a 9 percent decrease in submissions from the previous year, with 257 rank lists submitted; among lists submitted, 222 lists were ranked, and 154 were matched.

PGY1 curriculum

The American Board of Neurological Surgery (ABNS) supports the RRC in an effort to improve the PGY1 experience in neurosurgery. The board believes that neurosurgical program directors should have more control over the educational content of the PGY1 experience, which should include rotations relevant to neurosurgery, such as neurology; emergency medicine; orthopaedic surgery; and ear, nose, and throat.

Resident duty hours

The ABNS is unflagging in its commitment to the welfare of residents and the safe delivery of care to neurosurgical patients. Neurosurgical program directors have rapidly come into compliance with the new ACGME guidelines on resident duty hours. A variety of strategies have been implemented to accomplish the objectives of neurosurgical residency training within these restrictions. They include the use of physicians' assistants and nurse practitioners for the delivery of care, and the use of "night-float" systems, all to ensure compliance with the duty-hour requirements.

There is a widespread perception among neurosurgical educators that we run the risk of developing a "shift-work" mentality among

our residents. We fear that the commitment to excellent care over the course of a patient's illness will not be sensed as keenly by current neurosurgical residents as it has been in the past. The board is concerned about this problem, which has the potential to change the standards of neurosurgical practice that have been developed over decades.

Training

The ABNS continues to advocate efforts to train neurosurgeons in the complete care of cerebrovascular disease, including all of the latest endovascular techniques. Catheter-based techniques to treat aneurysms, vascular malformations, and carotid disease are being taught during residency training, and the ABNS examinations reflect these new procedures.

In addition, the ABNS supports the training of neurosurgeons to provide stereotactic radiosurgery for the treatment of neoplastic, vascular, and functional disorders.

Primary examination

The ABNS written primary examination is administered annually to neurosurgical trainees. This multiple-choice examination covers the breadth of neurosurgery's clinical and basic science curriculum. It may be taken for self-assessment but must be taken and passed for credit toward certification prior to applying for oral examination and certification. For residents entering training after June 30, 1998, the training requirements of the ABNS and the RRC specify that the examination must be passed during training in order to complete residency successfully. Many program directors require trainees to pass the examination before progressing to chief resident.

In March 2005, the primary examination was administered to 528 examinees; 207 took the exam for credit and had a 16 percent fail rate. Among those sitting for the exam, 321 took it for self-assessment.

Oral examination

Oral examinations are the final step in the ABNS initial certification process. They are administered by the board each spring and fall to neurosurgical practitioners who have applied for certification. Candidates must have graduated from accredited neurosurgical residency training programs; hold unencumbered medical licenses and hospital privileges; demonstrate good professional standing as assessed by mentors and peers; and show satisfactory practice performance through review of a minimum of one year of current, consecutive, operative cases.

In November 2004, 89 candidates sat for the oral examination, with a 13 percent failure rate. In May 2005, 88 candidates were examined; the failure rate was 8 percent. Each candidate's performance is scored numerically by six examiners. These grades are used to determine the pass/fail status by a computer program so as to maximize objectivity in the process. Standardized questions are now being used for a small portion of the examination.

Maintenance of certification (MOC)

The ABNS issued its first 10-year, time-limited certificates in May 1999. Since then, it has worked to develop all of the components of a neurosurgical MOC program that meets the requirements of the American Board of Medical Specialties (ABMS). The ABNS has now completed work on its MOC program and submitted a revised application to the ABMS.

- Part I, Evidence for Professional Standing, will include evidence of a full, unrestricted medical license, admitting privileges to practice neurosurgery, and a recommendation from the chief of staff of the primary hospital. These will be required every three years.

- Part II, Lifelong Learning and Self-Assessment, will also be a three-year requirement. It will include 150 hours—60 Category 1 and 90 Category 2—of strictly neurosurgical content for continuing medical education hours. Participants will also be required to take a Web-based self-assessment examination, specifically the Self-Assessment in Neurological Surgery (SANS) program developed by the Congress of Neurological Surgeons. This examination provides immediate feedback to participants regarding the correct answer for each of the 200 questions.

- Part III, Evidence of Cognitive Knowledge, will be fulfilled with a secure, comprehensive examination to be taken every 10 years. This will be developed in conjunction with and administered by the National Board of Medical Examiners.

- Part IV, Evidence of Performance in Practice, will be evaluated by review of “key cases.” Every three years, 10 consecutive cases will be submitted on one of the key cases selected from a list of procedures that includes the neurosurgical subspecialties. In addition, participation in a communication assessment tool will be required every three years, most likely a survey developed by the Consumer Assessment of Healthcare Providers and Systems® in conjunction with the ABMS. Feedback about communication skills will be given to the practitioner. The SANS program will contain material to help assess performance and educate in the areas of interpersonal skills, professionalism, practice-based learning, and systems-based practice. In addition, the questionnaire to the chief of staff will assess the participant's involvement in systems-based practice.

Letters and brochures outlining the MOC program were mailed to all ABNS diplomates in 2004 and 2005. At press time, the board was expected to roll out the program in early 2006.

Practice Data Project—NeuroLog

NeuroLog is an Internet-based, data-collection tool developed by the ABNS to facilitate the gathering of information necessary for initial certification and possibly MOC. It is additionally useful to program directors for the collection of resident case logs and other reports for the RRC. The system is highly secure and compliant with the Health Information Portability and Accountability Act.

Applicants for primary certification now use NeuroLog to record all inpatients during a 12-month period. The program compiles the information and creates a summary report that fulfills one of the requirements of the application for certification. Not only does it provide all of the necessary data fields to complete this requirement, but also it is an efficient online mechanism for review of the data by the ABNS professional practice data committee.

Program directors use NeuroLog to accumulate data required for RRC accreditation. It tracks the necessary elements for residents and attending

physicians in order to meet current documentation standards. The cataloging of operative data is streamlined and yields both *Current Procedural Terminology* codes and appropriate ABNS/RRC procedural categories.

The ABNS anticipates that NeuroLog will also be the vehicle for Web-based data entry of key case information.

Revocation of certification

At its meeting in May 2005, the ABNS held hearings on revocation of three certificates. All three were revoked.

ABNS directors

At its spring 2005 meeting in St. Louis, MO, Ralph G. Dacey, Jr., MD, FACS, and Hal L. Hankinson, MD, completed their six years of contributions and leadership on the ABNS. Newly elected directors are Charles L. Branch, Jr., MD, FACS, and Tae Sung Park, MD. New officers for the 2005-2006 year are William F. Chandler, MD, FACS, chairman; and Jon H. Robertson, MD, and Dr. Popp, vice-chairmen. M. Sean Grady, MD, FACS, remains as secretary, and Marc R. Mayberg, MD, as treasurer.

The American Board of Ophthalmology

by William F. Mieler, MD, FACS, Chicago, IL

Certification examinations

The annual meeting of the American Board of Ophthalmology (ABO) was held November 4, 2005, in Philadelphia, PA.

The future dates for examinations were as follows: Written qualifying examination, March 28, 2006, and March 27, 2007; oral examination, June 9–11, 2006, in San Francisco, CA, and October 27–29, 2006, in San Francisco, CA; June 1–3, 2007, in Philadelphia, PA, and October 26–28, 2007, in Cambridge, MA.

The total number of diplomates certified at the November 2004 oral examination in San Francisco was 198; at the June 2005 oral examination in Philadelphia, 216 diplomates were certified. Eighty-four failed the examination and must repeat all six subjects.

The 2005 written qualifying examination was held on April 15 at three sites in the U.S. The questions in this examination were prepared by the written examination committee of the American Board of Ophthalmology and the Ophthalmic Knowledge Assessment Program Committee of the American Academy of Ophthalmology. It is the responsibility of the written examination committee to review and approve the final questions.

Of the 733 participants registered for the 2005 written qualifying examination, 643 took

the examination, 184 failed (28.62%), and 459 passed. Of the 184 who failed, 102 (55.43%) had failed previously. Of the 643 candidates who took the examination, 170 (26.44%) were repeat test-takers, and of these, 102 (60%) failed again. International medical graduates comprised 50 (7.78%) candidates and 24 (48%) failed. U.S./Canadian graduates comprised 593 (92.22%) candidates and 160 (26.98%) failed.

Of the 170 candidates repeating the written qualifying examination, 29 (17.06%) were international medical graduates and 141 (82.94%) were U.S./Canadian graduates. The candidates who passed the 2005 written qualifying examination plus the repeat test-takers from previous oral examinations provided a potential pool of 253 candidates for the November 2005 oral examination and 262 potential candidates for the June 2006 oral examination.

MOC examinations

Beginning in January 2006, two pathways of the maintenance of certification (MOC) process will be available online. The office record review (ORR) is an online self-review of clinical practice and will be available on-demand from January 10 through December 31, 2006. The Periodic Ophthalmic Review Tests (PORT) are Internet-based, self-review tests composed of 50 items each and

which will also be available online, on-demand from January 10 through December 31, 2006. The Demonstration of Ophthalmic Cognitive Knowledge (DOCK) is the secure, proctored, computer-based examination available at approximately 300 computerized testing centers for a period of one month each year. The first DOCK examination will be administered September 1 through September 30, 2006.

Before the 2006 change to the MOC process, the ABO recertification process consisted of a two-month, take-home written examination, certificate renewal examination, written (CREW), and the ORR examination. The 2005 CREW examination was administered as a take-home examination from February 1 through March 31, 2005. Of the 1,041 participants registered for this examination, 1,025 completed the examination, with 1,016 (99.12%) passing and nine (0.88%) failing.

The ORR was administered July 1 through July 31, 2004, and January 1 through January 31, 2005. Of the 148 participants registered for the July 2004 examination, 144 passed the review and four were incomplete. At the January 2005 examination, 621 were registered, with 618 passing and three incomplete.

Representation

The representative to the American College of Surgeons for 2005 was David T. Tse, MD, FACS, Miami, FL. The board's representatives to the residency review committee for the year 2005 were: James S. Tiedeman, MD, Charlottesville, VA; Martha J. Farber, MD, Delmar, NY; and James C. Orcutt, MD, Seattle, WA.

In December 2004 and June 2005, the residency review committee for ophthalmology reviewed 38 of 116 accredited ophthalmology residencies. With few exceptions, most programs continued to receive full accreditation with three- to five-year cycles assigned on the strength of the program's review.

The following directors became officers of the board for 2005: Chair, William F. Mieler, MD, FACS, Chicago, IL; and vice-chair, Donald S. Minckler, MD, Los Angeles, CA.

The two new board directors who took office January 1, 2005, are David W. Parke II, MD, Oklahoma City, OK, and Donald N. Schwartz, MD, Long Beach, CA.

The voting representatives to the American Board of Medical Specialties (ABMS) for 2005 included the following: Edward G. Buckley, MD, Durham, NC; Marilyn B. Mets, MD, Chicago, IL; Richard P. Mills, MD, Seattle, WA; and Dr. Schwartz. Dr. Mieler serves on the board of directors of ABMS, and Denis M. O'Day, MD, FACS, Nashville, TN, is on the ABMS board of governors.

Suzanne T. Anderson—vice-president of Meaghan Jared Partners, Inc., a management-consulting firm for physicians, hospitals, and other health care entities in Bellevue, WA—is the board's current public member. In addition to serving as a public member for the ABMS, Ms. Anderson has published and written extensively on health care management issues and recertification.

Board transitions: The ABO honored the following directors at the November 2004 board meeting and expressed appreciation for their contributions: Charles P. Wilkinson, MD (director, 1997-2004; chair, 2004), and Susan H. Day, MD (director, 1997-2004).

General information

A search committee for a new executive director of the ABO was appointed. The position of executive director is a five-year term, renewable for an additional five years. The current executive director, Dr. O'Day, is in the last year of his second five-year term and has been extremely effective as a leader and innovator. The committee interviewed eight excellent candidates for this position and unanimously recommended that John G. Clarkson, MD, be appointed as executive director. Dr. Clarkson is currently the dean of the Leonard M. Miller School of Medicine, formerly known as the University of Miami Medical School, and will be leaving this position when he assumes the office of executive director. Dr. Clarkson will remain on the ophthalmology faculty at the Bascom Palmer Eye Institute of the Leonard M. Miller School of Medicine.

The ABO and the American Academy of Ophthalmology have formed a liaison committee to discuss issues of importance to both organizations regarding MOC as well as primary certification. The representatives of this committee meet twice a year. Of prime importance have been the

discussions surrounding the development of the practicing ophthalmologist curriculum. This is the curriculum developed by the American Academy of Ophthalmology from which the ABO will develop questions for the MOC self-review tests (PORT) and the cognitive examination (DOCK).

An overview of the MOC process of the ABO can be found on its Web site, *www.abop.org*, and is outlined in the ABO newsletter (also available online).

The ABMS, in collaboration with the Federation of State Medical Boards (FSMB), has developed the Disciplinary Alert Notification Service (DANS). One of the requirements to sit

for the ABO examinations is to have a valid and unrestricted license as of the date of initial application and maintain that license throughout certification and MOC. The DANS assists the ABO in reviewing actions that may have been taken by state medical licensing boards on any candidate or diplomate. This new process will ensure that the ABO rules on licensure are maintained.

The task force on competence continues to work toward developing tools for fulfilling the program requirements for accreditation and fulfilling the ABO's expectations for resident evaluation in the competencies.

The American Board of Otolaryngology

by Robert H. Miller, MD, FACS, Houston, TX

Qualifying/certifying examinations

The 2005 written qualifying exam was administered April 15 in Chicago, IL. All candidates then participated in the oral certifying exam, which was conducted on April 16 and 17 by 109 individuals, including American Board of Otolaryngology (ABOto) directors, senior examiners, and guest examiners. Those candidates who did not achieve the qualifying score on the written exam did not receive credit for their oral scores. Exam results are as follows: Among 289 candidates who sat for the written exam, 275 passed and 14 failed; among the 286 who sat for the oral exam, 281 passed and five failed.

Otolaryngology training examination

The otolaryngology training examination was conducted on March 5, 2005, in more than 100 locations. More than 1,100 residents and practitioners participated in the exam. The most recent training exam was held March 4, 2006.

Board of directors

Officers remained unchanged in 2005: Harold C. Pillsbury III, MD, FACS, president; Jesus E. Medina, MD, FACS, president-elect; and Paul A. Levine, MD, FACS, treasurer.

H. Bryan Neel III, MD, FACS, completed his term as a director at the conclusion of the 2004 annual meeting in April, after many years of dedicated service to the ABO. Dr. Neel served as treasurer for six years, in addition to serving on many committees.

Gerald S. Berke, MD, FACS, of Los Angeles, CA, was elected to the board of directors.

Maintenance of certification (MOC)

In 2002, the ABOto began issuing 10-year, time-limited certificates. MOC is the program by which diplomates maintain/renew their certification. Diplomates certified before 2002 are not required to participate in the MOC program but may do so if they wish. As a member board of the American Board of Medical Specialties, (ABMS), the ABO must comply with certain ABMS requirements. More importantly, MOC is a process that promotes lifelong learning and the ongoing provision for up-to-date, high-quality patient care.

The four components of the MOC process include documentation of professional standing, documentation of lifelong learning and self-assessment, evidence of cognitive expertise, and evaluation of performance in practice. The ABOto has instituted part I of the MOC process

and is in the process of developing the other three components.

Neurotology

The ABOto conducted its second neurotology exam on April 18, 2004. Twenty-five examiners and 42 candidates participated; all candidates passed the exam.

Two pathways to permit individuals to take the neurotology exam remain open at this time: one for those who have completed Accreditation Council for Graduate Medical Education residency training in neurotology, and one for those who have not completed such training but who limit their practice to neurotology. The alternate pathway will close after 2011.

Sleep medicine

The ABOto is a sponsoring board of the newly established conjoint subspecialty certificate in sleep medicine. Otolaryngologists who meet the eligibility requirements may take the certifying examination. Otolaryngologists who would like more information about certification in sleep medicine are urged to contact the ABOto office at 713/850-0399.

Additional information

Information on ABOto policies and examinations, as well as information on the Scope of Knowledge Study (which defines the content of ABOto exams and requisite otolaryngology training), is available at www.aboto.org.

The American Board of Surgery

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

The American Board of Surgery (ABS) held its summer meeting June 26–28, 2005. Following are decisions reached at this meeting.

New ABS chair and directors

The tenure of ABS chair Barbara Bass, MD, FACS, ended June 30, 2005. Dr. Bass was thanked by all for her outstanding leadership and multiple new initiatives during the year.

Jeffrey L. Ponsky, MD, FACS, Cleveland, OH, was selected by the directors as the next ABS chair for the 2005-2006 year.

Five new directors were selected in 2005 and began their term officially with the June meeting: Karen Borman, MD, FACS; John Hanks, MD, FACS; Larry R. Kaiser, MD, FACS; Leigh Anne Neumayer, MD, FACS; and Randolph Sherman, MD, FACS. Drs. Borman and Neumayer were chosen from panels of nominees submitted by the Advisory Council for General Surgery to fill ACS positions on the board, whereas Dr. Hanks was nominated by the Southern Surgical Association, Dr. Kaiser by the American Board of Thoracic Surgery, and Dr. Sherman by the American Board of Plastic Surgery.

In January 2005, the ABS created three at-large director positions, to be added to the current 32 directors who are nominated by specific surgical organizations. The new positions will be filled from panels of nominees submitted directly to the ABS through open nomination by individuals or organizations (including self-nomination), rather than the traditional process of nomination only through sponsoring organizations. Candidates may not be nominated from institutions from which there is a presently sitting ABS director. The ABS is interested in increasing representation of surgeons in private or group practice to ensure its standards are appropriate for the needs of today's practicing surgeons. The institution of three at-large positions is intended to further this goal; in addition, the ABS will continue to work with its established nominating organizations toward ensuring a diverse board membership that is representative of the U.S. surgical community.

Criteria for nomination are as follows:

- Board-certified in surgery for at least 10 years
- Significant experience with resident surgical education

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- Extensive experience in surgical practice
 - Highly regarded by surgical peers
 - Experience as an ABS examination consultant or associate examiner highly desirable
 - Diversity in gender, race, and/or community practice setting desirable

Applications for the at-large positions will be accepted until September 1, 2005. At-large directors will have the same term, six years, as directors from sponsoring organizations and the same duties, including participation in three board meetings and three oral examinations each year (approximately three to four weeks total). ABS bylaws prevent a director from serving after age 65. A final determination of the new members was made in early January.

New certification status reporting

In response to requests from diplomates, the ABS decided at its June meeting to institute a new method of reporting a diplomate's certification history as well as to create a new type of certification status. Up until now, the ABS has used only the three status descriptions used by the American Board of Medical Specialties (ABMS): *In the examination process* (denoting that an individual has an approved application), *certified*, and *not certified*. Although the ABMS will continue to use these three classifications, the ABS will use for its own reporting of status several classifications in addition to the ABMS status classifications: *recertified*, *recertified (clinically inactive)*, *suspended*, *revoked*, and *deceased*. A start and end date will also be listed next to the status if applicable.

This expanded reporting will provide a more accurate and detailed description of a diplomate's certification history, particularly for diplomates who have retired from practice but require verification of past certification. In addition, the status *recertified (clinically inactive)* is a new designation created in response to diplomates who are not in active practice and are therefore unable to supply a list of operative cases but who wish to maintain their certification. These diplomates will not furnish operative data or practice assessments to the ABS and are differentiated from actively practicing diplomates. Diplomates who wish to convert from clinically inactive status to active recertified status will be required to

provide the additional practice requirements mandated by Part IV of the maintenance of certification (MOC) process.

Recertification examination in surgery

The recertification examination committee last month took a fresh look at the recertification examination in surgery in light of feedback from recent examinees. Over the past few years, diplomates have communicated to the ABS that the recertification examination contains items that do not seem directly relevant to the practice of general surgery. The recertification examination committee addressed these concerns for the 2005 recertification examination by analyzing the examination's content and deleting questions involving specialty content judged to be outside the core surgical knowledge reasonably required of a surgery diplomate.

Instituted in 1983, the recertification examination in surgery is seen by the ABS as a minimum standard of core knowledge fundamental to all practicing surgeons regardless of specialty. It is designed to focus on common problems faced by a specialist in surgery and to ensure that diplomates are staying current with medical literature and the latest treatment information as their careers progress. While the recertification examination committee sought to better define the examination's core content, no strong relationship between diplomates' specialty practice area and examination performance has ever been demonstrated—diplomates who have specialized in a particular field such as vascular surgery do as well on the examination as diplomates who have a broad practice in general surgery. The committee's recent work reinforced the examination's purpose while still recognizing the inherent heterogeneous nature of general surgery.

To further assist diplomates in preparing for the recertification examination, the ABS has posted on its Web site, www.absurgery.org, a complete examination content outline. This outline will also include the subjects within specialty areas that are considered important for the general surgeon to be familiar with, such as the following:

- Transplantation: Criteria for brain death and complication of immunosuppressive drugs
- Gynecology: Treatment of venereal lesions,

management of post-partum perineal infections, endometriosis involving the gastrointestinal tract, management of a rectovaginal fistula, and the evaluation of abdominal pain during pregnancy

- Urology: Management of operative ureteral injury and postoperative testicular torsion
- Anesthesiology: Analgesia in carcinoma of the pancreas and malignant hyperthermia

In making these changes, the recertification examination committee thought it was important to respond to diplomates' concerns regarding the examination and ensure that it focuses on surgery core content, while maintaining the examination's integrity as a measurement of surgical knowledge.

MOC

In developing the MOC program, the ABS realizes the importance of correlating the program's requirements to those of other organizations that also play a critical role in diplomates' practice. For the June board meeting, the ABS invited representatives of three such organizations—the Centers for Medicare & Medicaid Services (CMS), the Federation of State Medical Boards (FSMB), and the American College of Surgeons—to discuss their own initiatives for continuing professional development, particularly as they relate to the MOC requirement for assessment of performance in practice.

Dr. Bass, ABS chair for 2004-2005, began the session by presenting an overview of the ABS' MOC requirements as currently proposed, emphasizing the need to partner with outside organizations to avoid redundancy and provide meaningful standards that will lead to practice improvement and better patient care. She also highlighted the key role of the ABS and its diplomates in establishing standards for surgeons by surgeons before external entities define these parameters. By being proactive in the quality improvement debate, diplomates of the ABS can demonstrate their commitment to high-quality care to other organizations and the public and reinforce the meaning of board certification as an indicator of superior training and knowledge.

David Hunt, MD, FACS, medical officer for the CMS and an ABS diplomate, was the first guest speaker. Dr. Hunt also serves as the government

task leader for the Surgical Care Improvement Partnership (SCIP), the CMS' main surgical quality initiative. Dr. Hunt proposed working with the ABS toward safer, higher-quality outcomes by helping individual surgeons in meeting both organizations' goals while decreasing administrative barriers. He suggested that surgeons working in a SCIP hospital and participating in the ACS' National Surgical Quality Improvement Program (NSQIP) or CMS collection process could meet the new CMS requirements for quality assessment in hospitals. He also stressed that the CMS wants surgeons' input to create realistic and practicable solutions but cautioned that the CMS will move forward with its initiative whether surgeons act or not.

The next presentation was by Steve Schabel, MD, chair of the maintenance of licensure committee of the FSMB. Dr. Schabel began by noting that currently physicians are "licensed for life." The FSMB, however, recently asserted that state medical boards "have a responsibility to assure physicians maintain competence throughout their practices" and is looking at MOC as a way to fulfill this. Dr. Schabel also emphasized that the FSMB and MOC have the same goal—to protect the public—and the ABS MOC program, since it is created by surgeons, is better than any alternative from the FSMB. He also brought forth the issue of diplomates who are certified indefinitely, saying that the ABS and the ABMS needs to strongly encourage these diplomates to participate in MOC in order for it to be accepted widely as a viable program.

R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, then gave an overview of the development of NSQIP and its possible integration with MOC. He discussed NSQIP's introduction into Veterans Affairs (VA) hospitals and the subsequent sharp reduction in mortality and morbidity rates. Dr. Jones went on to explain how NSQIP is now being implemented at private hospitals across the U.S. and how the ACS is working to bring NSQIP to individual surgeons. To illustrate the latter, Dr. Jones demonstrated the ACS' new Web portal, accessible through its Web site, where surgeons can log in and confidentially track their outcome data. Surgeons would also be able to access the portal using a personal digital assistant (PDA).

The portal is currently in its pilot phase and could potentially provide another means for fulfilling the MOC practice assessment requirement.

Following these presentations, the directors of the ABS discussed various options for practice assessment that would add value, be accessible, and not be overly time-consuming for diplomates. It was agreed that surgeons should track and assess their performance in a manner that will lead toward practice improvement. The directors also evoked the need to assess diplomates' patient communication skills. Quality improvement programs such as SCIP, NSQIP, the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®), or even robust morbidity and mortality could fulfill some or all of the MOC requirement, which would not be verified until five years after recertification, or no earlier than 2010 for diplomates who recertified in 2005.

New advisory councils

At the January 2005 meeting, the ABS created three new advisory councils to complete the subspecialty structure of component boards and advisory councils. The new councils were in the areas of transplantation; gastrointestinal surgery; and trauma, burns, and critical care. These groups will be added to the existing component boards in Vascular Surgery and Pediatric Surgery and the Surgical Oncology Advisory Council (SOAC). Specific appointing organizations were designated to appoint members to each of these councils, and two additional specialty organizations were added to the appointing organizations for the SOAC. At the completion of this process, all specialty areas that operate within the rubric of general surgery are now included in the ABS structure and have formal input to the standing committees and executive committee of the ABS.

Surgical critical care certifying exam

At the June board meeting, the ABS also approved a policy change regarding the certifying examination in surgical critical care (SCC). As it is not uncommon for residents to pursue a SCC fellowship during their general surgery residency, these residents may now take the SCC certifying examination immediately fol-

lowing the fellowship rather than waiting until they have become certified in general surgery. Previously such residents had to wait to take the SCC examination until they had completed residency and been certified in general surgery, which often meant they were taking the SCC examination five or six years after completing the fellowship. Residents who are successful on the examination, however, will not be deemed certified in SCC until they achieve certification in general surgery.

An additional change in the SCC examination—that a surgical diplomate of the ABS who completed an anesthesia critical care fellowship would be admitted to the certification process in surgical critical care—was adopted. This change was made in acknowledgment of the fact that the curriculum of anesthesia critical care programs is now essentially identical to those in surgical critical care.

Lastly, a change was made at the January 2005 meeting in which it was decided to admit diplomates of all the ABMS surgical boards to the surgical critical care certification process if they complete an accredited SCC fellowship and the ABS SCC examination. Thus, specialists in neurosurgery, orthopaedics, and other surgical specialties may now become SCC certified by the ABS.

Vascular surgery certificate approved

On March 17, 2005, the ABS received approval from the ABMS to offer a primary certificate in vascular surgery, opening the opportunity for vascular surgeons in the U.S. to become directly board-certified in vascular surgery without first becoming certified in general surgery. Although five other ABMS member boards currently offer more than one primary certificate, the ABS will be the first surgical board to do so.

The application for this new certificate was made by the ABS in partnership with the Society for Vascular Surgery and the Association of Program Directors in Vascular Surgery. The new certificate will provide the flexibility to create new types of vascular surgery training programs, such as one consisting of three years of general surgery training followed by three years of vascular surgery training, leading directly to certification in vascular surgery.

American Board of Surgery: Summary of 2004-2005 examinations

Examination	Number of examinees	Pass no. (%)	Fail no. (%)	Total # diplomates
Qualifying	1,287	999 (77.6)	288 (22.4)	
Recertification	1,562	1,445 (92.4)	118 (7.6)	15,312
Vascular surgery (qualifying)	127	106 (83.5)	21 (16.5)	
Vascular surgery (recertification)	153	148 (96.7)	5 (3.3)	1,371
Surgical critical care (qualifying)	108	92 (85.2)	16 (14.8)	2,178
Surgical critical care (recertification)	99	76 (76.8)	23 (23.2)	985
Hand surgery (qualifying)	5	5 (100)	0 (0)	231
Hand surgery (recertification)	27	22 (81.5)	5 (18.5)	114
Pediatric surgery ITE	72	---	---	
IT/SBSE	7,456	---	---	
Certifying	1,252	1,044 (83.4)	208 (16.6)	50,418
Vascular surgery CE	117	98 (83.8)	19 (16.2)	2,463
Total	12,265			

N/A = Not applicable

ITE/SBSE = In-training examination/surgical basic science examination

4,737 examinees, excluding the ITE/SBSE and pediatric ITE examinees.

Vascular surgeons will still have the option of completing a full surgery residency and becoming certified in general surgery before entering vascular surgery training.

With this approval, the ABS has decided that it will now offer only a primary certificate in vascular surgery, to be fulfilled by completion of a minimum of two years of vascular surgery training. The certificates of current vascular surgery diplomates will be automatically converted to the new primary certificate when they recertify in vascular surgery. One-year vascular training programs will be granted a three-year window to transition to two-year accreditation in order to fulfill this new requirement. Pending approval from Accreditation Council on Graduate Medical Education's (ACGME) Residency Review Committees and the ACGME itself, the new certificate will go into effect July 1. Eligible individuals will be able to submit an application before then for the 2006 qualifying examination in vascular surgery. The requirement for prior

certification in general surgery will continue until the official implementation of the new certificate on July 1.

LCSB appeals board denies ABVS appeal

The American Board of Vascular Surgery (ABVS) applied to the ABMS for independent vascular board status in May 2003. This was opposed by the ABS on the basis that a validated and respected method for vascular surgery certification was already in place and had been used since 1982; more than 2,200 vascular surgery diplomates of the ABS are certified. The initial application was heard in December 2003 by the Liaison Committee for Specialty Boards (LCSB) and was denied. ABVS appealed this decision and the appeal was heard by a specially appointed panel of the LCSB in February 2005. The final decision of this group was published in March 2005 and the denial of independent board status was upheld.

The American Board of Thoracic Surgery

by Carolyn E. Reed, MD, FACS, Charleston, SC

The American Board of Thoracic Surgery (ABTS) will offer specialty pathways and will increase the operative requirements for candidates for certification.

In response to current practice patterns in thoracic surgery, and to ensure adequate preparation for contemporary thoracic surgery practice, the ABTS has revised the standards required of individuals to qualify for entrance into its certification process.

The board has established two primary pathways to certification, a cardiothoracic surgery pathway and a general thoracic surgery pathway. An additional special certificate pathway will be established for candidates who complete the cardiothoracic surgery pathway and plan to perform congenital heart surgery. The new operative case requirements are on the board's Web site at www.abts.org.

The new specialty pathways and operative case requirements will be effective for individuals entering a thoracic surgery residency in July 2007 or later.

After much deliberation and in consultation with other thoracic surgery organizations, including the Residency Review Committee for Thoracic Surgery (RRC-TS), the Joint Council for Thoracic Surgery Education (JCTSE), and the Thoracic Surgery Directors Association (TSDA), the board has established new operative case criteria, with revised case requirements for both primary pathways and added qualifications for congenital heart surgery.

Maintenance of certification

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 a maintenance of certification (MOC) program to replace the current recertification process. In March 2005, the board mailed to each diplomate an outline of the current MOC plan, which has the following four components: (1) professional standing, (2) life-

long learning and self-assessment, (3) cognitive expertise, and (4) evaluation of performance in practice. Diplomates were asked to comment on the existing MOC plan; the board will revise the proposal based on the feedback received.

Recertification

Diplomates who hold time-limited certificates are expected to continue with the recertification process until MOC is implemented. 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 before 1976 do not require recertification and are considered to hold unlimited certificates.

The deadline for submitting recertification applications is May 10 of each year. 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. Additional information concerning the recertification requirements can be found in the annual *Recertification Booklet of Information*.

Inactive status

Diplomates holding a valid ABTS certificate and who expect to be clinically inactive for a period of one year or more may apply for inactive status. Application must be made, in writing, to the board, and approved, in writing, in advance of 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. For more information on the new inactive status policy, visit the board's Web site at www.abts.org.

ABTS recertification activity (current through 2005)

Date of orig. cert.	Total # cert.	Total # recert. first time	% recert. first time	Total # recert. second time	% recert. second time	Total # recert. third time	% recert. third time
Before 1976	N/A	68	–	4	–		
1976	160	142	89	128	80	34	21
1977	146	129	88	108	74	20	14
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	106	79		
1985	120	119	99	102	85		
1986	147	140	95	85	58		
1987	141	137	97	53	38		
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	148	95				
1995	159	151	95				
1996	160	113	71				
1997	121	43	36				

Examinations

The board administered its ninth criterion-referenced part II (oral) examination to 132 individuals June 10–11, 2005. The pass rate for the examination was 86 percent. The next oral exam will be held June 2–3 in Chicago.

On December 5, 2005, the board administered its thirteenth criterion-referenced part I (written) exam to 164 individuals. The pass rate for the examination was 85 percent. This was the second time the written exam was administered in a computer-based format at Pearson Profes-

sional Testing Centers. By offering the exam in a computer-based format, the candidates were able to take the exam at a site conveniently located close to their homes. The ABTS would like to acknowledge and thank the American Board of Surgery (ABS) for helping to make the computer exam possible.

Pathways and requirements for 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:

1. Successful completion of a full general surgery residency (five years) approved by the Accreditation Council for Graduate Medical Education (ACGME) 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 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. Before this pathway is implemented, the RRC-TS must first approve institutions to offer such programs. As of this report, no institutions have received accreditation for a categorical-integrated thoracic surgery residency.

Joint training program

The ABTS and ABS worked closely together to develop joint training programs leading to the possibility of certification by both boards. Institutions interested in offering the joint training program may apply for accreditation with the RRC-Surgery and RRC-TS.

Applications

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

In-training examination

The 2005 in-training exam was administered online on April 16 and April 23 to 375 residents and fellows. The in-training examination con-

sists of general thoracic and cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination. The 2006 in-training examination is April 1 and April 8.

New board of directors

At the 2005 fall meeting, Richard H. Feins, MD, FACS, was elected vice-chair of the ABS. The following thoracic surgeons were elected to be directors of the ABTS: George L. Hicks, Jr., MD, FACS, representing the Thoracic Surgery Directors Association; Bruce W. Lytle, MD, FACS, representing the American Association for Thoracic Surgery; and Richard J. Shemin, MD, FACS, representing the American Surgical Association. 