

Report of the American Board of Surgery to the Central Surgical Association March 2009

The American Board of Surgery met in Cancun, Mexico for five days under the direction of Dr. Russell Postier, Chair, on January 10-14, 2009. The following issues were addressed:

Modular (Focused Practice) Recertification

The American Board of Internal Medicine (ABIM) has proposed to ABMS that a new procedure for the recognition of expertise in a focused area of practice be developed for use in maintenance of certification. This would be specifically targeted to areas in which expertise is developed after residency as a result of a specific practice environment, and would allow explicit recognition of subspecialty areas of practice where the focus of practice has narrowed. Such areas would be distinguished from, and would not overlap with, areas where subspecialty certificates are offered, because they would not necessarily require additional fellowship training after residency, nor would any subspecialty examination be given. The principal impetus for this has come from medical hospitalists within ABIM, who normally receive no training beyond basic medical residency, but who limit their practice to the in-hospital environment. ABMS held a two day task force meeting in early December to discuss whether to proceed with this initiative, and several problems became evident. It was felt to be a way of providing recognition for specific expertise that develops as a result of practice, rather than fellowship training, but it was also felt that it would be confusing to the public and would be difficult to distinguish in their mind from subspecialty certification. ABMS has not yet taken a final stand on the issue.

This issue was the subject of a retreat held on Sunday, January 11, and was subsequently discussed at the main meeting on January 14. Several pros and cons were brought out, and it was specifically noted that of the four parts of MOC, the issues of focused practice are already possible in regard to Part II (CME and self-assessment) and Part IV (performance in practice). Part I is generic, relating to licensure and professionalism, and hence is not subject to focused practice. That leaves only Part III, the secure examination, as a real focus. The issue then is whether a diplomate should be able to recertify by taking a modular examination which is concentrated in a narrower area of surgery than the general examination is customarily given. There are significant problems in doing this, both in finding sufficient questions in a narrow area, e.g., breast surgery, to allow a psychometrically valid examination, and in having sufficient numbers of diplomates taking the examination to give statistically adequate results. Lastly, there is the philosophical issue of whether it is a good idea to recertify a diplomate in surgery on the basis of an examination which is not targeted to the broad range of surgical subjects. The opinion was expressed by a number of directors that allowing a focused examination to be taken for recertification would only encourage fragmentation of surgery, when in fact the principal public need is for more generalists. It was also agreed that any attempt to identify a subspecialty area of focused practice on the certificate would be extremely confusing to the public in regard to differentiating it from subspecialty certification as it already exists.

After extensive discussion and an expression of the ranges of opinions on this issue, the Board voted, and on a split vote (18-13) decided not to proceed with the possibility of modular recertification. It was agreed as noted above that Parts II and IV already may be focused in a modular area, but it was felt that the secure examination, which is not extremely difficult for an active practitioner to prepare for, should not be changed.

IOM Report and Response

The recently released report of the Institute of Medicine regarding resident work hours was the subject of extensive discussion, both in formal and informal sessions. The report has recommended that the 80 hour limit remain unchanged, but that a maximum shift length of 16 hours be allowed, after which at least 5 hours of uninterrupted sleep be required. Total shift length is limited to 30 hours. It was the universal opinion of directors that the proposal is unworkable in the context of surgical residency, and that it cannot be implemented effectively in the real world in which residents are required to give patient care. In addition, there was great concern expressed that the entire area of work hours restriction was giving residents the message that their sleep cycle is more important than patient welfare, and there have already been multiple reported examples of residents who violate present work hour restrictions because of their personally perceived obligations to care for patients and provide continuity of care.

The Board formally requested the staff to prepare a white paper which will address the problems of the IOM proposals in regard to surgical residency, and to provide this to the ACGME prior to their scheduled symposium on March 3-4 at which this issue will be addressed. Several directors volunteered to be part of the writing committee if needed.

Public Members

The Board decided at the June meeting to add two public members, and several individuals have been nominated by the directors. There was discussion of the desirable credentials at the meeting and further nominations were solicited, to be sent to the Board office within a week after the conclusion of the meeting. All names, with short bios, will be compiled and then mailed out to all directors for evaluation and prioritization. Once a prioritized list is available, the individuals will be approached and asked if they would be willing to participate as public members, given the obligation to attend at least two meetings per year.

American Board of Radiology Proposal for Vascular Interventional Radiology Primary Certificate

The American Board of Radiology has sent a proposal to the ABMS (COCERT) asking that a primary certificate in Vascular Interventional Radiology be created separate from the present certificate in Diagnostic Radiology. This would entail five years of residency, and would begin with one year of surgical residency, followed by 18 months of diagnostic radiology and 24 months of interventional radiology, as well as 6 months of additional clinical time involving complex patient management. The Vascular Surgery Board reviewed this proposal in depth, and prepared a critique of the proposal, which primarily focused on the disparity between the level of clinical skills envisioned, and the amount of clinical training required. The intent of the certificate is to prepare an interventional radiologist who can individually provide pretreatment and evaluation, interventional radiology treatment, and posttreatment followup. It was the strong opinion of the VSB that the amount of clinical training provided in the application for the certificate was insufficient to prepare a radiologist to evaluate and adequately plan management of these complex

patients, and that the total of 18 months of clinical time would not in fact provide adequate background. It also was felt that the certificate would alter the role of interventional radiology as it currently functions in the management of vascular patients, and that it was not clear the training outlined would be sufficient to allow this level of change in responsibilities. As a result the VSB, and subsequently the full Board, took a strong position in opposition, and this opinion will be transmitted to COCERT prior to their meeting in February at which this certificate will have its first reading.

Certification in Surgical Oncology

The Surgical Oncology Advisory Council discussed in depth a white paper which they have prepared outlining the pros and cons of proposing to the Board that a new certificate in surgical oncology be created. SOAC is not yet prepared to move ahead with this, but anticipates that they may have this prepared by the June 2009 meeting of the Board, and if so, will present the proposal at that time. The Board has discussed this issue at recent meetings, and there is divided opinion as to whether the creation of a surgical oncology certificate would be desirable or not, or whether it would result in the exclusion of general surgeons who could not qualify, but have a significant degree of oncology in their practices. No formal proposal was brought forward at this time, and SOAC will discuss this further with the membership of the Society of Surgical Oncology before finalizing the proposal.

ABMS Proposals for Maintenance of Certification Standards

The Committee on Maintenance of Certification (COMMOC) of ABMS has published the second draft of their proposed standards for MOC, and has formally asked for comments to be submitted by January 31. This was reviewed by the Diplomates Committee, and subsequently by the full Board, and was felt to contain several unworkable and excessively expensive proposals. In particular, a proposal that CAHPS surveys be required of all diplomates at five year intervals, that all diplomates be required to complete a 20 hour patient safety course, and that all diplomates undergo 360 degree evaluations at five year intervals were all thought to be unworkable, and unproven in regard to their beneficial impact on patient safety or quality of care. The expense of each is also high, and if all were implemented, it would at least double the present cost of recertification. As a result the Diplomates Committee made a strong recommendation that the ABS take a position in opposition to the recommendations as drafted, and so inform COMMOC prior to the deadline for comment. It is anticipated that COMMOC will evaluate the feedback and make final recommendations for the MOC Standards at the March 2009 ABMS meeting.

Board Certification for International Graduates

The issue of allowing Board certification for international graduates without requiring a period of residency training in the United States has been raised by various organizations, and in particular has been discussed in conjunction with the Maintenance of Licensure initiative from the Federation of State Medical Boards. This was discussed in the Diplomates Committee, and it was felt that perhaps some method may be found for allowing highly qualified international graduates who have worked for some period of time in academic centers to qualify for Board certification in the future. However, when trying to draft specific proposals that would clearly define candidates who were qualified for Board certification, it was clear that this will be quite difficult to define sufficiently narrowly to ensure that those allowed to proceed to certification actually have the necessary broad credentials. In particular, if there is no period of residency training, there are many characteristics of the individual in practice which cannot be evaluated, and the quality and breadth of training programs in various countries are extremely variable. Thus, in discussion at the general meeting, it was felt by the diplomates that we should proceed slowly in

this area and not loosen the restrictions prematurely, as it would be nearly impossible to reverse an action once it was taken.

New Directors

New directors have been elected from the following organizations to serve a six-year term starting July 1, 2009:

American Medical Association – Stephen Evans, M.D.

American Pediatric Surgical Association – Ronald Hirschl, M.D.

American Surgical Association – Selwyn Vickers, M.D.

American Society of Transplant Surgeons – Douglas Hanto, M.D.

Dr. Evans will replace Dr. Russell Postier, Dr. Hirschl will replace Dr. Marshall Schwartz, Dr. Vickers will replace Dr. Carlos Pellegrini, and Dr. Hanto will replace Dr. James Schulak, all of whom are completing their terms of office.

It should also be noted that Dr. Larry Kaiser's term of office expired in June, and he was succeeded by Dr. Cameron Wright from the American Board of Thoracic Surgery.

Necrology

We were saddened to learn of the deaths of Clement A. Hiebert, July 3, 2008, and Lloyd M. Nyhus, December 15, 2008, Senior Members of the American Board of Surgery.

Respectfully submitted,

Fabrizio Michelassi, M.D.

CSA Representative to the ABS

AMERICAN BOARD OF SURGERY

SUMMARY OF 2008-2009 EXAMINATIONS*

Examination	# of Examinees	# Pass	# Fail	Pass Rate	Fail Rate	D
Qualifying	1, 261	989	272	78.4%	21.6%	
Recertification	1,750	1,647	103	94.1%	5.9%	
Vascular Surgery QE	110	95	11	88.2%	11.8%	
Vascular Surgery Recert.	174	163	11	97.4%	2.6%	
Surgical Critical Care	165	134	31	81.2%	18.8.%	
SCC Recertification	132	114	18	86.4%	13.6%	
Hand Surgery	6	3	3	50.0%	50.0%	
Hand Surgery Recert.	11	10	1	90.9%	9.1%	
Pediatric Surgery ITE	78	---	---	N.A.	N.A.	
ITE – Junior Level Exam	3,940	---	---	N.A.	N.A.	
ITE – Senior Level Exam	3,670	---	---	N.A.	N.A.	
Certifying	1,261	1,027	234	81.4%	18.6%	

Vascular Surgery CE	133	112	21	84.2%	15.8%	
TOTAL						

N.A. = Not applicable.

examinees, excluding the ITE and PITE.

**Note – shaded rows show results for 2007-2008 academic year; 2009 examinations not yet completed*