



# ABS News

The Newsletter of the American Board of Surgery

## Surgery Certification Requirements to Change

The American Board of Surgery (ABS) used the first day of its January meeting to discuss the proposed changes of the Residency Review Committee for Surgery (RRC-Surgery) regarding the training requirements of surgery residents. As part of the Accreditation Council for Graduate Medical Education (ACGME), the RRC-Surgery sets the requirements for surgery residency programs in the U.S. In a recent review of these standards, the RRC-Surgery proposed modifications to increase emphasis on training in the essential content areas of general surgery.



Dr. David Feliciano, chair of the ABS General Surgery Residency Committee, leads the discussion on the requirement changes proposed by the RRC-Surgery.

L.D. Britt, M.D., and J. David Richardson, M.D., to attend the January board meeting to establish a common set of requirements that address the interests of both organizations.

One of the most pivotal changes proposed was to increase the number of residency months spent in the essential content areas of surgery from 36 to 48, out of a total of 60 months of residency. After much discussion, a requirement of 42 months was agreed on by both organizations. The number of months to be spent in clinical rotations overall

will remain at 54, allowing residents the opportunity to spend up to six months performing research or a non-clinical rotation.

Another fundamental change agreed on by both parties was to raise the number of operative cases required overall from 500 to 750. The ABS was amenable to this change as its statistics show that only 3 percent of graduating surgery residents do not attain 750 cases during residency. Additionally, residents may now count cases in which they acted as teaching assistant toward this total; however, teaching assistant cases may not be counted toward the required 150 chief resident cases. In additional amendments, rotations in thoracic surgery will now be acceptable in the chief year although it is not an essential content area, and also in transplantation, provided the chief resident has significant direct operative experience. The ABS will continue to require applicants to complete either a rotation or have operative experience in transplantation. Both organizations concurred on the need for more robust rotations in transplantation and committed themselves to working with the American Society of Transplant Surgeons to improve the quality of residency transplant training.

In other changes, while the ABS will continue to list “trauma/burns” as an essential content area, the RRC-Surgery will still only list “trauma” but it will now count burn rotations as a rotation in the essential content areas.

### Key Requirement Changes

- 42 months to be spent in clinical rotations in the essential content areas of surgery (previous: 36)
- 750 operative cases required (previous: 500)
- Residents may count cases as both teaching assistant and surgeon toward the 750 total
- Rotations in thoracic surgery and transplantation allowed in chief year

### ABS Essential Content Areas

- Alimentary Tract
- Abdomen and Its Contents
- Breast, Skin and Soft Tissue
- Endocrine System
- Head and Neck Surgery
- Pediatric Surgery
- Surgical Critical Care
- Surgical Oncology
- Trauma/Burns
- Vascular Surgery

The two organizations also came to agreement on other, less significant wording changes, and the ABS agreed to re-examine the wording of its requirements for laparoscopy and endoscopy to see if greater emphasis is needed. These changes will all take effect July 1, 2007, and will be reflected in the 2007-2008 *ABS Booklet of Information* to be published this summer. For the future, the ABS and RRC-Surgery will form a joint committee of representatives to regularly review surgery residency program requirements and make any changes in common so the requirements of both organizations remain consistent.

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COURTNEY M.  
TOWNSEND, JR., M.D.  
Chair of the ABS  
2006-2007

The ABS continues to press forward with a range of projects intended to expand and improve surgeons' opportunities for professional growth from residency to

retirement. The ABS is working with major organizations engaged in surgical education and quality improvement to foster education, training and assessment that reflects current best practices. With the rapid growth of surgical knowledge and technology, along with the advent of Maintenance of Certification (MOC) and other quality initiatives, the ABS is taking an active role in assuring that surgery residents will be able to meet the demands of current surgical practice, and that once certified, all diplomates are staying up to date on the latest surgical advances and evaluating their practice performance.

The ABS was pleased to meet in January with representatives of the RRC-Surgery to discuss their proposed changes to surgery residency curriculum in an effort to increase focus on the essential content areas of surgery. While we agreed with the RRC's intent in proposing these modifications, we also wanted to permit residents some freedom to customize their training to suit their chosen field of practice. The ABS believes the changes agreed on fulfill the goals of both parties. The two organizations will continue to coordinate their requirements in the future to avoid presenting differing standards.

Also in the area of residency education, the SCORE initiative is proceeding

on schedule with the development of a new, innovative curriculum for surgery residency. The members of SCORE represent the principal organizations involved in surgical education, including those charged with setting standards for graduate surgical education. The ABS believes the main outcome of SCORE, a multimedia website covering 40 core topics of general surgery, will encourage a greater level of consistency and quality in surgery training.

In addition, the ABS is devoting extensive energy to creating a Maintenance of Certification program that features valid measures of a diplomate's performance in practice. The ABS is committed to exploring every possible option that would provide a viable and meaningful way to track surgical outcomes to fulfill the Part 4 requirement of MOC—*Evaluation of Performance in Practice*. MOC is the surgical community's opportunity to set the agenda and standards of surgical quality reporting, rather than reacting to external mandates. The ABS intends to work with state and federal agencies as well as private health insurers to position MOC as a widely-accepted standard of health care quality. This topic will be further discussed at the ABS' next meeting in June, where a panel of experts in the area of quality assessment will be convened to provide their input.

As the ABS proceeds with all of these initiatives, we welcome your insight and feedback.

Visit the ABS on the Web  
at [www.absurgery.org](http://www.absurgery.org).



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# ABS Hosts Inaugural Meeting of SCORE

*Surgical Council on Resident Education is formally organized*

On November 20, the ABS hosted the inaugural meeting of SCORE, the Surgical Council on Resident Education, whose task is to examine the current state of surgical training and develop a new curriculum for use by all surgery residency programs in the U.S. SCORE is composed of representatives from the principal organizations involved in surgical education—the American College of Surgeons (ACS), the American Surgical Association (ASA), the Association of Program Directors in Surgery (APDS), the Association for Surgical Education (ASE), and the RRC-Surgery, in addition to the ABS. The meeting was organized by ABS Assistant Executive Director Richard H. Bell, Jr., M.D., as a first step in developing a comprehensive program for improving the training of U.S. surgeons.

SCORE emerged from the growing concern of the ABS and other organizations that traditional surgical training no longer can respond sufficiently to the pressures of the modern health care environment, and that the quality of graduate surgical education and the overall attractiveness of surgery as a specialty are threatened. The rapid growth of new technology and surgical knowledge, along with limits on residency work hours and a pro-



*The members of SCORE at the November 2006 meeting: top row (l-r) Dr. Timothy Flynn (ABS), Dr. L.D. Britt (RRC-S), Dr. Barbara Bass (ACS), Dr. Gary Dunnington (APDS), Dr. R. James Valentine (APDS), Dr. David Feliciano (ABS), Patrice Blair (ACS); bottom row (l-r) Thomas Biester (ABS), Dr. Robert Rhodes (ABS), Dr. Richard Bell (ABS), Dr. Hiram Polk (ASA), Doris Stoll (RRC-S), Dr. Frank Lewis (ABS), Dr. Joseph Cofer (APDS), Dr. J. David Richardson (RRC-S), Dr. Carlos Pellegrini (ASA), Dr. Ajit Sachdeva (ACS) and Dr. Donald Risucci (ASE); not pictured: Dr. John Potts (APDS).*

jected shortage of surgeons in the near future, are all factors that prompted the creation of SCORE and inspired its objective of a new, innovative curriculum for surgery residency training. The ABS has seen first-hand an undeniably high degree of variability in the knowledge of graduated surgery residents, particularly regarding complex trauma and gastrointestinal cases. In the fall of 2004, representatives of the aforementioned organizations met at the ABS office and voiced unanimous support for the creation of a nationwide surgery curriculum to address these issues. Dr. Bell, then chair of the ABS General Surgery Residency Committee, was recruited in June 2006 to oversee this project and the organization of SCORE.

At the November 20 meeting, SCORE representatives reviewed the past and current work of its member organizations in improving surgical education and the attractiveness of surgery as a career choice. They reviewed the proposals of the ASA Blue Ribbon Panel on the restructuring of surgical training, published in January 2005, and

ultimately decided that SCORE would focus on opportunities for improving the traditional five-year surgery curriculum rather than restructuring the curriculum into a shorter time frame. They also learned about the surgical skills curriculum being created in a separate project by the ACS and APDS, and the ACS' development of a basic curriculum for the first year of surgical residency. The council was enthusiastic about both of these projects and agreed to their integration into the new curriculum.

The members of SCORE also agreed to move ahead with the development of a website dedicated to the project that will serve as the focus for organizing and disseminating material for residents, using multimedia resources and interactive features. The APDS, under the principal direction of John R. Potts, III, M.D., will have responsibility for generating most of the required content for the curriculum and website. At the heart of the curriculum will be 40 modules determined by the APDS and ABS to cover the key subject areas of general surgery and their related conditions, diseases and procedures.

*(Continued on page 6)*



*Dr. Ajit Sachdeva describes the ACS' project of a PGY-1 curriculum for surgery residency at the November SCORE meeting.*

## New Initiatives for MOC

New features and programs continue to be developed for use in Maintenance of Certification. MOC is a program of continuous professional development created by the ABS with the American Board of Medical Specialties (ABMS) that replaces traditional recertification with a process of continual learning, assessment and improvement. ABS diplomates are automatically enrolled in MOC upon certification or recertification after July 1, 2005.

The ABS has been working with the ABMS and other member boards to develop a patient feedback mechanism that could be incorporated into the Part 4 requirement, *Evaluation of Performance in Practice*. Such a tool would assess a diplomate's skills regarding patient communication and management. Though other ABMS boards have already instituted patient feedback programs, the ABS felt it important to ensure that any such program implemented by the ABS be directly relevant to surgeons and surgical practice. Members of the ABS Diplomates Committee are currently

testing the CAHPS® Clinician & Group Survey to see if it could be adapted for this purpose in an easy-to-use manner. The ABS, ABMS and other member



boards are also investigating if a common patient survey device could be implemented among health plans, consumer groups, government payers and physicians organizations. To date, Aetna, United Healthcare, Cigna, Humana and WellPoint have expressed interest in such a project.

The ABMS has also developed a patient safety module for use by all of its member boards scheduled for release in 2007. The ABMS Patient Safety Module will be web-based and enable diplomates from all ABMS boards to learn essential knowledge

and skills related to patient safety that can be applied to their specific practice environment. Completion of this module would be credited toward a diplomate's Part 4 activity. The ABS and ABMS also continue to be in discussions with the Federation of State Medical Boards (FSMB) on how the FSMB and ABMS member boards can align their requirements to reduce redundancy.

A main focus of the ABS' June 2007 meeting will be the further definition of the Part 4 requirement. The ABS believes strongly that the tracking and benchmarking of outcomes is the most relevant method of performance evaluation for a surgeon, and wants to investigate feasible methods for outcomes tracking that could be incorporated into the MOC process. The ABS hopes to assemble national leaders in the field of surgical outcomes at the June meeting to develop practical approaches by which all ABS diplomates can track and assess their outcomes.

For more information about MOC, visit [www.absurgery.org](http://www.absurgery.org).

### ABS MOC Program Requirements

MOC is an evolving process; the requirements outlined below for the four parts of MOC will be modified as new learning and assessment tools are developed. MOC years run from July 1 to June 30, beginning the July 1 following certification or recertification.

#### Part 1: Professional Standing

- Full and unrestricted **medical license**, to be verified every three years.
- **Reference letters** from the chief of surgery and chair of credentialing/privileges committee to be submitted every three years.

#### Part 2: Lifelong Learning and Self-Assessment

- A minimum of 30 hours of Category I and 50 hours overall of **continuing medical education (CME)** to be performed yearly and verified every three years. **Self-assessment evaluation** in conjunction with the CME to be performed and verified every three years.

#### Part 3: Cognitive Expertise

- Successful completion of a **secure examination** at 10-year intervals; diplomates may first take the examination starting three years prior to certificate expiration.

#### Part 4: Evaluation of Performance in Practice

- Participation in a national, regional or local surgical **outcomes database or quality assessment program**, verified every three years. In cases where no such program is available, the ABS will consider the use of individual practice data. Participation in CMS' Physician Voluntary Reporting Program (PVRP) meets this requirement.
- Participation in periodic **communication skills assessment** based on patient feedback (not yet finalized).

Diplomates who fail to provide the necessary documentation after three years of MOC will be given a warning and a one-year grace period before loss of their certification status.

## Update: Vascular Surgery Primary Certificate

Since the primary certificate in vascular surgery was fully approved in 2006, several institutions have applied to the RRC-Surgery for approval of integrated training programs leading solely to certification in vascular surgery. To date, three institutions have been approved for five-year integrated training programs: Dartmouth-Hitchcock Medical Center, University of Michigan and University of Pittsburgh.

The Vascular Surgery Board of the ABS (VSB-ABS) is currently in the process of specifying the general surgery training that will be required of graduates of integrated programs in order to be accepted into the vascular surgery certification process. To ensure that these graduates have a sufficient level of knowledge in general surgery, the VSB-ABS has decided that individuals who do not become certified in general surgery prior to vascular surgery certification will have to pass a special computer-based examination in general surgery as a prerequisite. This requirement will apply to all individuals who complete vascular surgery training pathways that involve fewer than five years of general surgery and individuals who

complete a general surgery residency but do not pursue general surgery certification.

As the primary certificate went into effect July 1, 2006, individuals who completed general surgery residency before this date must adhere to prior requirements and obtain certification in general surgery before applying for vascular surgery certification. After this date, individuals may become eligible for vascular surgery certification through completing: (1) the traditional 5+2 pathway, with or without general surgery certification; (2) an early specialization program of 4+2 that leads to certification in both general surgery and vascular surgery, or (3) vascular surgery training in a newly approved integrated program. Further details regarding the requirements for vascular surgery certification are available from [www.absurgery.org](http://www.absurgery.org).



The VSB-ABS goes over the requirements for vascular surgery certification at the January ABS meeting. Pictured: (closest, l-r) Dr. James Seeger, Dr. Thomas Riles, Dr. Kim Hodgson, Dr. Anton Sidawy; (farther l-r) Dr. John Ricotta, Dr. Jonathan Towne, Dr. William Jordan; not pictured: Dr. Bruce Gewertz.

### Other VSB-ABS Initiatives

The VSB-ABS is also moving forward with the development of an in-training examination in partnership with the Association of Program Directors in Vascular Surgery, since now all training programs must be two years in length. The exam will first be administered in 2008. Additionally, the VSB-ABS is working with the Society for Vascular Surgery to create a self-assessment examination for vascular surgeons that could be used to fulfill the Part 2—*Lifelong Learning and Self-Assessment*—requirement of MOC.

## Postier Elected Vice-Chair



Russell G. Postier, M.D., was elected this summer as vice-chair of the ABS for 2007-2008. He will serve as ABS chair in 2008-2009. Dr. Postier was named to the ABS in 2002 as a representative of the American Medical Association. He has since held several committee positions within the ABS and acted as the board's representative to the American Board of Medical Specialties.

A native of Oklahoma, Dr. Postier received his undergraduate degree from Oklahoma State University. He then graduated from the University of Oklahoma College of Medicine and

completed his surgery residency at Johns Hopkins University Hospital. He joined the University of Oklahoma as assistant professor of surgery following residency and in 1997 was appointed the John A. Schilling Professor and Chair of the university's department of surgery.

Dr. Postier is a past president of the Southwestern Surgical Congress and a member of the board of governors of the American College of Surgeons. Dr. Postier will begin his role as vice-chair starting July 1, 2007.

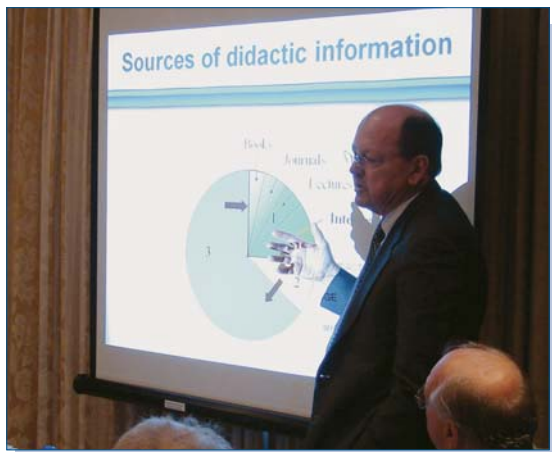
## SCORE (cont.)

(Continued from page 3)

The 40 modules are intended to encompass the learning needs of surgery residents from medical school to entry into practice after completion of five years of residency. The modules and the curriculum as a whole are expected to be continually updated as technology and medical knowledge evolve.

As part of the project, SCORE intends to survey recently certified diplomates about their training to gain insight into what aspects they found most and least effective in preparing them for practice. SCORE will also interview groups of current residents to learn more about their perceived educational needs. In addition, Joseph B. Cofer, M.D., and Timothy C. Flynn, M.D., will be attending in February

a meeting of surgery program directors in the United Kingdom, as the Royal College of Surgeons of England has just completed a project similar to SCORE. A detailed description of the entire SCORE initiative will be published in the March issue of the *Journal of the American College of Surgeons*.



Dr. Richard Bell presents his research on residents' current resources for surgical education at the November meeting of SCORE.

### SCORE Curriculum Modules

- Abdomen - biliary
- Abdomen - general
- Abdomen - hernia
- Abdomen - liver
- Abdomen - pancreas
- Abdomen - spleen
- Alimentary tract - esophagus
- Alimentary tract - stomach
- Alimentary tract - small intestine
- Alimentary tract - large intestine
- Alimentary tract - ano-rectal
- Breast
- Endocrine
- Endoscopy
- Genito-urinary
- Gynecology
- Hand
- Head/Neck
- Miscellaneous
- Nervous system
- Organ transplant
- Othopaedics
- Pediatric surgery
- Plastic surgery
- Skin and soft tissue
- Surgical critical care
- Thoracic
- Trauma
- Vascular - access
- Vascular - amputation
- Vascular - aneurysm repair
- Vascular - aortic obstructive
- Vascular - cerebrovascular
- Vascular - diagnostic
- Vascular - endovascular therapeutic
- Vascular - extra - anatomic
- Vascular - miscellaneous
- Vascular - peripheral obstructive
- Vascular - upper extremity
- Vascular - venous

## ABS Updates

### New Certificate in Hospice and Palliative Medicine to Be Offered

Along with several other ABMS member boards, the ABS will be introducing a certificate in hospice and palliative medicine in 2008. An ABS diplomate may become eligible for this certificate by either completing 12 months in an ACGME-accredited training program or by demonstrating clinical competence in hospice and palliative medicine. The latter option, which is available for only the first five years of the certificate, requires either a minimum of 800 hours of clinical involvement during the past five years, including at least two years and 100 hours of participation with a hospice or pallia-

tive care team and active care of at least 50 terminally ill patients, or prior certification by the American Board of Hospice and Palliative Medicine and evidence of clinical activity during the past two years.

### Joint General/Thoracic Surgery Training Programs

General surgery residents now have the option of pursuing a joint program in general and thoracic surgery leading to certification in both disciplines. Three joint programs have been approved to begin in July 2007 and more institutions are expected to apply. Certification in general and thoracic surgery through this pathway requires successful completion of a

joint training program approved by the RRC-Surgery and RRC-TS. The program encompasses four years of general surgery training followed by three years of training in thoracic surgery, which must be completed at the same institution.

### New "Your Surgeon Is Certified" Brochure Coming Soon

The popular *Your Surgeon Is Certified* brochure from the ABS is currently being redone. The new version will feature updated text and new graphics. Order forms will be sent to all diplomates once the brochure is printed this spring.

## ABS Examination *Innovations*

Most of us can remember a professor in college who dusted off the same exams each year to give to students. Unlike this professor, the ABS is constantly evaluating and improving its examinations and exam processes.

One of the most recent examples of an improved process occurred this summer, when the ABS was able to provide results for the Surgery Qualifying Examination (QE) only eight days after the exam had been held. Thanks to the conversion of the QE to a computer-based examination and prior efforts to streamline the processing of QE results, the quick posting of results provided successful examinees with ample time to sign up for one of the five Surgery Certifying Examinations given subsequently during the academic year. It is now entirely possible for a graduated resi-

dent to obtain full surgery certification within six months of residency completion.

Other innovations have taken place with regard to ABS in-training examinations. As of last year, the Surgery In-Training Examination (ABSITE) is given in two versions: a junior-level version for PGY 1-2 focusing mostly on basic science, and a senior-level version for PGY 3-5 concentrating on clinical management. The ABS believes the separate versions allow the ABSITE to more accurately gauge residents' knowledge appropriate to their residency level. In another advance, the Pediatric Surgery In-Training Examination will be given this year as an online examination through an external web-hosting service. If successful, the ABS hopes to eventually move the ABSITE, the ABS' last remaining pencil-and-paper examination, to this format.

As for ABS oral examinations, the Vascular Surgery Certifying Examination is planned to be held in 2008 using a new, multimedia format. While the examination will still use in-person examiners, it will be



held at the offices of the American Board of Obstetrics and Gynecology (ABOG) to take advantage of ABOG's specially equipped examining rooms that permit the viewing of computer images and video for each case.

For recertification exams, every year the ABS analyzes the operative experience submitted by recertification applicants to assess if the content of the examinations is appropriately weighted based on diplomates' scope of practice. In addition, the ABS recently instituted a requirement that all directors and examination consultants who submit items for ABS exams must attend a workshop on best practices in examination writing.

The ABS strives to ensure that its examinations reflect current surgical knowledge and practice, and utilize the latest examination delivery technology. The ABS welcomes the input and feedback of diplomates toward these goals.



*The Pediatric Surgery Board of the ABS takes a break at the January ABS meeting while discussing the transition to an online in-training examination. Pictured (l-r): Dr. Marshall Schwartz, Dr. Keith Oldham, Dr. Mary Fallat, Dr. Jessica Kandel, Dr. Thomas Tracy, Dr. David Schmeling.*

### Important 2007 Dates

#### Surgery Recertification Examination

Application Deadline:

Aug. 1, 2007

Late Application Deadline:

Sep. 4, 2007

Exam Dates:

Nov. 26 - Dec. 8, 2007

#### Pediatric Surgery, Vascular Surgery and Surgical Critical Care Recertification Examinations

Application Deadline:

July 2, 2007

Late Application Deadline:

July 16, 2007

Exam Dates:

Oct. 1 - 13, 2007

#### Pediatric Surgery and Vascular Surgery Qualifying Examinations, Surgical Critical Care Certifying Examination

Application Deadline:

July 2, 2007

Late Application Deadline:

July 16, 2007

Exam Date:

Oct. 1, 2007

# ABS Seeks Associate Executive Director/Director of Evaluation

The American Board of Surgery announces that it is recruiting for the full-time position of associate executive director/director of evaluation to be located at the ABS offices in Philadelphia. The successful recruit will replace the retiring incumbent, with an expected start date of January 1, 2008. The principal focus of the position will be oversight of the development process for all ABS written and oral examinations in general surgery and surgical specialties, as well as the psychometric validation, item analysis, scoring, and statistical analysis of examination results. In addition, participation in the general administrative activities of the office in a position equivalent to chief operating officer, in the review and approval of examination applications, and in the oversight of

oral certifying examinations is expected. Candidates for this position must be board certified in surgery and have extensive academic experience, expertise in surgical residency education, and experience in test development and statistical analysis. Prior surgery department or medical education administrative experience is essential in positions such as division head, hospital department chief, department chair, or designated institutional official. Peer recognition by membership in academic surgical societies is necessary. The candidate selected must possess the ability to independently exercise initiative and creativity, and play an instrumental role in the future of the board's programs and activities. Special expertise and experience in regard to the oversight of item banking,

examination development, and statistical evaluation of examinations is necessary. The position requires moderate amounts of travel within the continental U.S. to attend certifying examinations, as well as attendance at selected surgical meetings.

Applications for this position will be accepted until May 31, 2007. All applications and inquiries should be sent to the attention of Frank Lewis, M.D., Executive Director, American Board of Surgery, 1617 JFK Blvd., Ste. 860, Philadelphia, PA, 19103. Applicants will be initially screened on the basis of their written application and curriculum vitae. Final selection will be by the ABS Executive Committee and will require ratification by the full board of directors. Further details are available from the ABS website, [www.absurgery.org](http://www.absurgery.org)

## 2006-2007 ABS Examination Statistics

ITE – In-Training Examination, PS – Pediatric Surgery, VS – Vascular Surgery, SCC – Surgery Critical Care, HS – Hand Surgery

Examination	Examinees	Pass Rate	Diplomates (to date)	Examination	Examinees	Pass Rate	Diplomates (to date)
Surg Qualifying	1,268	77%	N/A	VS Qualifying	125	90%	N/A
Surg Certifying	1,301	84%	53,360	VS Certifying	121	84%	2,564
Surg Recertification	1,578	94%	16,790	VS Recertification	142	97%	1,528
ABSITE	7,486	N/A	N/A	SCC Certifying	128	87%	2,362
PS Qualifying	64	97%	N/A	SCC Recertification	125	86%	1,095
PS Certifying	67	91%	995	HS Certifying	1	100%	236
PS Recertification	92	92%	601	HS Recertification	11	91%	133

The ABS welcomes your input! Send your ideas and comments about this newsletter to [cshiffer@absurgery.org](mailto:cshiffer@absurgery.org).



## ABS News

Winter 2007

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