Report of the American Board of Surgery to the
American Society of Transplant Surgeons
January 2008

The American Board of Surgery convened its winter meeting from January 5-9 at Amelia Island, Florida under the direction of Dr. Tim Flynn, Chair. The principal issues addressed are summarized below:

Curriculum Initiative

The curriculum initiative continues to move forward under the direction of Dr. Richard Bell. A meeting of the Surgical Council on Resident Education (SCORE) in November led to adoption of the curriculum outline of diseases and operations that the General Surgery Residents' Committee, under the direction of Dr. Stan Ashley and Dr. Bell, had adopted previously. This outline has been vetted for approximately two years by various groups, including surgical program directors, and is now in final form. It was presented to the Executive Committee and the full Board at this meeting and adopted as the definition of the areas which general surgery residents are expected to master. It is expected that the curriculum will be a "living" document which will be reviewed and updated yearly, but is presently ready to become the defining document for the domain of general surgery and as such, will supplant the essential content areas and primary components which have defined general surgery in prior documents.

Dr. Bell is also moving forward with development of a website which will have the primary purpose of providing teaching material to residents organized according to the curriculum outline. It is anticipated that a preliminary version of this will be ready for release in July 2008 to a limited group of residency programs for alpha testing and feedback, with the intent of finalizing the website design by the end of 2008. Dr. Bell and Dr. Ashley are working with the Association of Program Directors in Surgery, and in particular Dr. Gerald Doherty, in developing approximately 100 modules by July 2008 which will parallel the subjects in the curriculum outline.

Maintenance of Certification

The Board continues to grapple with the development of specific requirements for Part IV of Maintenance of Certification – Performance in Practice. It is felt that outcomes measurement for surgical procedures is the most meaningful standard to be used in Part IV, but except for hospitals which have adopted the NSQIP methodology, such measurements are generally unavailable. Process measurements, which are the current foundation of Medicare recommendations, are useful, but do not provide specific focus on operations that will lead to the most definitive assessment of outcomes. Currently the measures which have been advocated are related to the timing and appropriateness of prophylactic antibiotics, and the use of DVT prophylaxis in high risk patients. In addition, for cardiac patients, the appropriate use of beta blockers is included. None of these measures have relevance to specific operations, and do not address the complications/risks which are associated with specific operative procedures.

The Board is working cooperatively with the American College of Surgeons to address the lack of data in this area, and is specifically looking to the case logging system provided by the College to Fellows, which allows detailed recording of complications related to specific

operations. It is anticipated that diplomates of the Board who document their complications in this system will meet the requirements of Part IV at the present time, so long as this record provides a complete compilation of cases done.

American Board of Medical Specialties

The ABMS has selected a new president to replace Dr. Steve Miller, who retired in December after 9 years as CEO of the organization. Dr. Kevin Weiss has been selected as his replacement, and assumed his position December 17. Dr. Weiss is an internist and primary care physician based in Chicago who has been heavily involved in national medical quality discussions in various organizations, particularly the Ambulatory Care Quality Alliance (AQA) and the National Quality Forum (NQF). He is well-versed in the quality debates in Washington, and is a respected figure among multiple organizations and constituencies. His initial agenda for the ABMS indicates an activist agenda in which he will seek to make the ABMS more clearly an agency which is focused on the interests of the public in promoting high quality medical care. He will seek to move the agenda beyond board certification only, with a greater focus on enhancing maintenance of certification by the various boards.

Vascular Surgery

A meeting was held in December between representatives of the Society for Vascular Surgery (SVS) and the leadership of the Board to address issues of concern raised within the SVS. At the June meeting of the SVS, the Council of that organization severed its long-standing ties with the American Board of Vascular Surgery (ABVS), and focused on the continuing development of the primary certificate in vascular surgery, and the development of vascular surgery as a separate specialty, independent of general surgery. With the dramatic change in the nature of vascular surgery during the last 10 years, and the increased role of endovascular technologies, general surgery residents are no longer trained to treat the full spectrum of arterial vascular disease, and vascular surgery fellowship is now an essential requirement for finishing residents who wish to specialize in that area. The role of the Vascular Surgery Board of the ABS (VSB-ABS), which has had full control of vascular surgery certification standards and examinations for the last 11 years, needs to be recognized by appropriate changes in the ABS Bylaws, and the SVS has agreed to promote this recognition within their membership. Cordial discussions occurred, and the issues raised will be addressed by the ABS and SVS over the next 6-12 months.

Accreditation of Non-ACGME Accredited Fellowships

The problem of post-residency fellowships which are not accredited by the ACGME has been a long-standing problem that the Board has highlighted. Fellowships which award certificates, such as cardio-thoracic, colon-rectal, plastic surgery, vascular surgery, and pediatric surgery, all have fellowships which are accredited by the ACGME, and are subject to monitoring by RRC's in general surgery, thoracic surgery and colon-rectal surgery. In addition, some fellowships are overseen and accredited by specialty societies, such as surgical oncology fellowships (Society for Surgical Oncology) and transplantation (American Society of Transplant Surgeons). The Fellowship Council is also in the early stages of initiating an accreditation process for GI and minimally invasive fellowships. Most other fellowships are not formally accredited, and training standards, quality monitoring, and assessment of training quality, are not assessed by any independent organization. Since all of these fellowships are similar in providing post-residency

training for surgical residents, the variability in certification standards is irrational and leads to serious questions about value and uniformity of training.

The American College of Surgeons has recognized this problem, and has convened a task force under the direction of Dr Gerald Healy to evaluate the problem and determine whether the ACS should take on the task of accrediting post-residency fellowships which are not accredited by the ACGME. This effort is in the early stages of evaluation and discussion, and no timetable or definite plan has been formulated to date.

Residency Education in Transplant Surgery

The RRC for Surgery, in fall 2006, voted to discontinue the requirement of transplant rotations in surgical residency, based on the highly variable quality of these rotations, and the contention of program directors that the rotations often were not educationally useful. The Board subsequently asked the RRC to stay this action, and approached the leadership of the American Society of Transplant Surgeons, specifically through the initiatives of Dr. James Schulak, Chair of the Transplantation Advisory Council. A meeting was held between the leadership of the ASTS and the ABS in April 2007 to discuss the problem, and the fact that transplant surgery can potentially offer valuable training and experience to surgical residents, but that transplant program directors would have to make a specific commitment to resident teaching if the transplant rotations were to be retained.

The ASTS, over the summer, has mounted a major effort to define a curriculum for transplant surgery that should be taught at various levels of residency, and to define the operative experience that should be expected of residents at different levels, in order to enhance the teaching value. These initiatives have been adopted by the ASTS and are in the process of implementation. The RRC has agreed to hold off any further action until these initiatives have a chance to be implemented and evaluated, and it is hoped that improved educational experience will follow. The major problems still occur in programs which do not have a transplant program within the same hospital, as these residents must be sent to other institutions to obtain transplant experience, and they generally have difficulty in fully participating there as a member of the transplant team. This problem will be monitored in an ongoing way, but the ASTS is to be congratulated on a positive and comprehensive effort to address the problem.

Recommendation for Certification in Surgical Oncology

The Society for Surgical Oncology (SSO) has forwarded to the Surgical Oncology Advisory Council (SOAC) a formal request that the ABS create a certificate in surgical oncology. They have indicated a willingness to have surgical oncology fellowships be accredited by the ACGME to meet this standard. The SOAC is recommending that the Board formally evaluate this proposal, and specifically its impact on general surgical training and practice, before deciding whether to proceed. Dr. Carlos Pellegrini, Chair of SOAC, presented this recommendation to the full Board at the January meeting, and the Board agreed to move forward with an evaluation plan over the next six months, prior to making any decisions about the certificate.

Primary Certificate in Surgical Critical Care

The Trauma, Burns, Critical Care Advisory Council has been discussing the merits of creating a primary certificate in surgical critical care, which would not require prior certification in general

surgery. In preliminary discussion, it is envisioned that the training for this certificate would be four years in length after medical school, and that it would involve a mix of general surgical and critical care training during that period. Residents finishing this program would be expected to limit their practice to critical care, and would not be qualified for independent operating. It is felt that the evolution of critical care as a separate discipline has created the need for this training, and that many medical student graduates today would find this to be an attractive career pathway. The Surgical Critical Care Program Directors are planning a sample survey of surgical residents and medical students at selected institutions in the next six months to evaluate the response to this proposal, and seek to assess the level of interest in such a training pathway.

Necrology

We were saddened to learn of the deaths of the following Senior Members: Harvey E. Beardmore, February 2007; Robert J. Freeark, December 2006 (Memorial Service, February 2007); and G. Tom Shires, October 18, 2007.

AMERICAN BOARD OF SURGERY

SUMMARY OF 2006-2007 EXAMINATIONS

Examination	# of Examinees	# Pass	# Fail	Pass Rate	Fail Rate	Total # Diplomates
Qualifying	1,293	1,010	283	78.1%	21.9%	
Recertification	1,703	1,601	102	94.0%	6.0%	17,535
Vascular Surgery QE	106	95	11	89.6%	10.4%	
Vascular Surgery Recert.	174	163	11	93.7%	6.3%	1,612
Pediatric Surgery QE	65	62	3	95.4%	4.6%	
Pediatric Surgery Recert.	122	116	6	95.1%	4.9%	660
Surgical Critical Care	128	116	12	90.6%	9.4.%	2,464
SCC Recertification	101	89	12	88.1%	11.9%	1,146
Hand Surgery	6	3	3	50.0%	50.0%	239
Hand Surgery Recert.	13	13	0	100.0%	0%	146
Pediatric Surgery ITE	78	---	---	N.A.	N.A.	
ITE – Junior Level Exam	3940	---	---	N.A.	N.A.	
ITE – Senior Level Exam	3670	---	---	N.A.	N.A.	
Certifying	1261	1027	234	81.4%	18.6%	54,198
Pediatric Surgery CE	67	61	6	91.0%	9.0%	995
Vascular Surgery CE	133	112	21	84.2%	15.8%	2,676

TOTAL **12, 866**

N.A. = Not applicable.

5,172 examinees, excluding the ITE and PITE.