**Meeting Summary**

**American Board of Surgery**

**June 27-30, 2015**

**1. Meeting and Membership**

The Board met in Philadelphia under the leadership of Dr. David Mahvi, Chair, during the above dates. Newly elected directors who attended this meeting and their sponsoring organizations are the following:

Dr. Marwan Abouljoud – American Society of Transplant Surgeons

Dr. Marjorie Arca – American Pediatric Surgery Association

Dr. Mary Hawn – American Surgical Association

Dr. O. Joe Hines – Society for the Surgery of the Alimentary Tract

**2. Residency Redesign**

Plans for residency redesign have been at the top of the ABS’s agenda for the last two years, and it is anticipated that it will continue to be a priority for several years into the future. The need for residency redesign has been discussed for some time, but there is no general agreement on exactly what the problems are and what needs to be altered. Changes in residency training in the last 20 years have been profound in regard to the types of surgical cases done, the way in which they are done, the time that residents spend in the hospital during surgical training, and the attitudes of surgical residents in regard to work/life balance. Most of the environmental and cultural variables which have altered surgical training are not reversible, so the challenge of redesign is to find other factors which can be modified to improve training and to make it more efficient or effective. Given the complexity of the problem, as well as the constraints of the present system, there is little agreement in regard to needed actions.

Surgical residents tend to differentiate into two broad training pathways – one for the 20-25% of graduates who complete 5 years of residency and enter practice as a “general” general surgeon with a broad practice encompassing multiple areas of general surgery. The second pathway is for the other 75-80% of graduates who complete post-residency fellowships in a specialty and generally limit their practices to narrower specialty or sub-specialty areas.

Most of the perceived problems reside in the basic five year general surgery training program, and there are few complaints about the subsequent fellowship training, which is generally perceived to be adequate, despite the variability in the accreditation mechanisms for various types of fellowships (ACGME accredited v. specialty society accredited v. non-accredited). The discussion has therefore focused on the basic five year training program and potential modifications to that.

For residents who intend to practice in a specialty area, the present five year surgery residency is felt to be too long, and there is a desire to shorten this in order to focus on specialty training earlier. This is highly desired by medical students, and venues which have offered early concentration in a specialty have been highly popular (Early Specialization Programs and integrated programs in vascular and thoracic surgery). It is felt that the “core” training in general surgery could be shortened to a more focused four year experience, with specialty concentration beginning in the fifth year, with a sixth and/or seventh year of specialty fellowship to follow.

Many feel that general surgery training should be considered as a “specialty” the same as all the others, and should have the same type of training pathway – i.e., a sixth year of general surgical “fellowship”. There is another equally convinced cadre of surgeons who insist that five years is enough, and that the current products of the five year program are fully competent.

The Board has already provided for the Flexibility in Training Initiative, by which program directors may devote up to 6 months per year from the PGY-3 year onward to specialty rotations during residency, with a total limit of 12 months during three years. In addition, the Board has decided to allow the Qualifying Examination to be optionally taken after the PGY-4 year if residents wish to do so, and have satisfied all of the requirements for completion of residency. This change is planned for July 2016, for those residents who wish to move into more concentrated specialty training in the PGY-5 year.

The other initiatives which the Board is taking are to examine in detail what the components are for “competency based” education, and to examine closely the changes which are being made by the Royal College in Canada, which has been involved in residency redesign for at least five years. In order to reduce the core training in general surgery to four years, as intended, it will be necessary for residents to improve the efficiency of their learning, and to gain greater and more complex operative experience at an earlier time. The specific methods for achieving this are not presently defined, either in this country or any others that we are aware of. The Executive Committee of the Board is committed to developing a multiyear effort to move ahead with residency redesign, and to learn as much as we can from others who are doing the same thing, as well as from the educational establishment more broadly.

**3. Maintenance of Certification**

Extensive controversy has developed across the country in regard to the requirements and value of maintenance of certification. This has been precipitated by the American Board of Internal Medicine, which created a rebellion among cardiologists initially, and then more generally among a broader group of diplomates. The basic issues were requirements which were perceived as too onerous, not meaningful to most practitioners, and too expensive. The rebellion has led to the creation of a new non-ABMS “board”, designated as the National Board of Physicians and Surgeons, and organized by Dr. Paul Teirstein at the Scripps Clinic in La Jolla. This effort was initially targeted only at medicine specialties, but has expanded over the last few months to cover all specialties. Dr. Teirstein’s board offers maintenance of certification for lesser requirements and charges than ABIM or other boards, and largely removes any requirements for Part IV. He is currently working to have his board become acceptable to hospitals, HMO’s, and insurance companies as an alternative to ABMS boards, so that he can offer an alternative to current diplomates of all the boards. His degree of success is unknown at the moment, but he has forced ABIM to back down on their MOC requirements, and to put them fully in abeyance for two years while ABIM redesigns their whole program. The impact of Dr. Teirstein’s efforts on the surgical boards so far appears to be minimal, but long term results are not predictable.

ABS has not to date been affected by any of this, as virtually none of the complaints directed at ABIM apply to the MOC program of the ABS. Nevertheless, the Board is looking closely at the MOC program and trying to determine what other approaches would be more useful to surgeons in maintaining their education while not being onerous in regard to their time commitments.

**4. Osteopathic Residency Accreditation**

The accreditation of osteopathic residencies by the ACGME will begin July 1, 2015, and it is anticipated that all of the surgical residencies (now numbering in the 50’s) will apply for accreditation within the first two years. The ABS has determined that it will require osteopathic residents to complete a minimum of three years in an osteopathic residency after it becomes ACGME accredited in order to qualify for entry into the general surgical certification process. Osteopaths who wish to enroll in a surgical (sub) specialty fellowship will have to be eligible for certification in general surgery before they are eligible for certification in the subspecialty. Osteopathic subspecialty programs will have to be accredited for the entire duration of fellowship in order to qualify for entry into the ABS processes.

**5. SCORE Update**

The SCORE website usage continues to grow steadily, and now extends to several venues outside the US. All but 2 of the allopathic surgical residencies currently subscribe to SCORE, and in addition several vascular surgery and pediatric surgery programs are subscribing, a total of 321 programs that are ACGME accredited. In addition, nearly 80% of the osteopathic surgical programs subscribe, as well as 7 of the 17 Canadian programs. There are 54 international programs which subscribe, including all 40 of the programs in the Netherlands, and all in Singapore. There are 436 programs that are subscribed overall, with more than 10,000 residents enrolled.

The program has finally moved into the black financially after several years of heavy subsidies from the ABS, and contributions from the ACS, ASA, and APDS. There was a small profit in 2013-14, and a slightly larger one is projected for 2014-15, of the order of 5% of revenue. All of the original modules in general surgery have been reviewed and brought up to date, and all of the general surgical modules are fully built out. Modules to meet the requirements of pediatric surgery and vascular surgery fellowships are being added and should be completed by July 2016.

We have had several requests from diplomates for individual subscriptions, and these became available as of July 1, 2015. We are initially targeting fellows who have recently completed surgical residency, and are familiar with the program, as we feel they will be most likely to want to continue to use it.

**6. International Activities**

The collaboration of ABS with the Ministry of Health and surgical residencies in Singapore continues to move forward, with the first written examination scheduled for March 2016. Surgeons involved with the Singaporean programs have been quite active and involved in the process, and the ABS is providing expertise and some basic materials and questions in order to get them started, but it is anticipated that within 3-5 years the effort will be entirely managed by surgeons in Singapore with minimal oversight by ABS. Dr. Buyske has been the person most heavily involved in this, and visits Singapore approximately twice yearly to keep the effort on track.

In recognition of the global disparities in access to safe surgical care, in December 2014 the ABS joined the G-4 Alliance as a founding member.  The G-4 Alliance is an advocacy group focusing on global needs in surgery and anaesthesia care.  The initial main focus of the group was to work with the World Health Organization to drive adoption of resolution WHA68.15, "strengthening emergency and essential surgical care and anesthesia as a component of universal health coverage."  Such resolutions, when adopted, help focus health care dollars from foundations, grants, and governments towards the areas identified by the WHA.  The G-4 Alliance accomplished this goal, and continues to work in advocacy for access to surgery worldwide.  ABS director Fizan Abdullah is the President of the G4 Alliance and Jo Buyske is the ABS member of the Board of Governors.

**7. New Officers**

Dr. Stephen Evans, who is the Chief Medical Officer for the MedStar System in Washington, DC, became chair of the ABS at the conclusion of the June meeting, and will continue through June 2016. He will be followed by Dr. John Hunter, Chair of Surgery at Oregon Health and Science University, in the 2016-17 academic year. Dr. Mary Klingensmith will succeed him in the 2017-18 year. Other members of the Executive Committee of the Board are Dr. Karen Brasel, Oregon Health and Science University, and Dr. K. Craig Kent, Chair of Surgery at the University of Wisconsin.

**SUMMARY OF AMERICAN BOARD OF SURGERY EXAMINATIONS: 2014-2015**

Summary data of all 2014-2015 ABS examinations are presented in Table 1. A total of 14,969 examinees participated in these examinations throughout the year. Excluding the General Surgery, Pediatric Surgery, and Vascular Surgery In-Training Examinations, there were 5,315 American Board of Surgery examinees in 2014-2015. The total number of examinees is generally similar to most prior years.

TABLE 1

AMERICAN BOARD OF SURGERY

**SUMMARY OF 2014-2015 EXAMINATIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Examination** | **# of****Examinees** | **# of Items\*** | **Average P****Total\*\*** | **Passing****Score** | **Failure****Rate** |
| Qualifying | 1,367 | 286 | 75.9 | 72.7 | 23.5% |
| General Surgery MOC | 1,462 | 205 | 75.2 | 63.0 |  4.7% |
| Vascular Surgery QE | 141 | 262 | 75.9 | 68.0 |  5.7% |
| Vascular Surgery MOC | 178 | 262 | 76.4 | 65.0 |  6.2% |
| VS Surgical Principles | 8 |  97 | 72.9 | 70.0 | 25.0% |
| Surgical Critical Care | 217 | 210 | 73.0 | 64.0 |  7.8% |
| SCC MOC | 100 | 212 | 72.4 | 60.0 |  4.0% |
| Pediatric Surgery QE | 50 | 192 | 74.1 | 67.0 |  6.0% |
| Pediatric Surgery MOC | 45 | 192 | 72.9 | 62.0 |  8.9% |
| Hand Surgery | 9 | N.A. | 65.9 | 65.0 |  33.3% |
| Hand Surgery MOC | 12 | N.A. | 72.0 | 60.7 |  8.3% |
| Complex GS Oncology QE | 74 | 160 | 78.3 | 74.0 |  9.5% |
| Hospice & Palliative Care | 12 | N.A. | 70.6 | N.A. | 41.7% |
| Vascular Surgery ITE | 510 | 273 | 71.1 | N.A. | N.A. |
| Pediatric Surgery ITE | 115 | 209 | 68.0 | N.A. | N.A. |
| ITE  | 8,301 | 242 | 70.1 | N.A. | N.A. |
| ITE – International | 422 | 242 | 58.4 | N.A. | N.A. |
| ITE – D.O.s | 306 | 242 | 64.3 | N.A. | N.A. |
| Certifying GS | 1,374 | N.A. | N.A. | N.A. | 23.1% |
| Vascular Surgery CE | 149 | N.A. | N.A. | N.A. |  8.7% |
| Pediatric Surgery CE | 54 | N.A. | N.A. | N.A. |  9.4% |
| Complex GS Oncology CE | 63 | N.A. | N.A. | N.A. | 11.1% |
| **TOTAL** | **14,969** |  |  |  |  |

N.A. = Not applicable

\* Number of items after deletion

\*\* P = Percent correct

5,315 examinees, excluding the ITE, VSITE, and PSITE